



# **COMPLIANCE AND ETHICS PROGRAM POLICIES (SYSTEM-WIDE)**

Updated May 2025

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

**SUBJECT:** Compliance and Ethics Program, Detecting and Preventing Fraud, Waste and Abuse, System-Wide

**ORIGINATING DEPARTMENT:** Compliance

**EFFECTIVE DATE:** October 1, 2010

**BOARD COMPLIANCE COMMITTEE APPROVAL DATE:** 5/14/2025

**LAST PERIODIC REVIEW DATE:** 4/23/2025

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**PURPOSE:** To detect and prevent Fraud, Waste and Abuse in healthcare operations.

**ENTITIES AFFECTED:** All ArchCare-sponsored entities

**SCOPE:** This policy applies to the workforce<sup>1</sup> of ArchCare and its affiliated entities. Specifically, ArchCare “[w]orkforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term “workforce” also applies to contractors, subcontractors, agents or independent contractors<sup>2</sup> who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

**POLICY:** ArchCare and its affiliated entities are committed to preventing and detecting any fraud, waste and abuse in the organization. To this end, ArchCare maintains a vigorous compliance program and educates its workforce regarding the importance of

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<sup>1</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

<sup>2</sup> This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

submitting accurate claims and reports to federal and state governments, as well as regarding the requirements, rights and remedies of federal and state laws governing the submission of false claims, including the rights of employees to be protected as whistleblowers under such laws.

ArchCare prohibits the submission of a false claim for payment to a federal or state health care program. Such a submission violates the federal False Claims Act as well as various State laws and may result in significant civil and/or criminal penalties.

To assist in meeting its legal and ethical obligations, ArchCare expects any workforce member who is aware of or reasonably suspects the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse to report such information to his/her supervisor, the Compliance Officer of the facility or program where he/she is employed, the Corporate Compliance Officer of ArchCare (646) 633 4401, or to call the Compliance & Corporate Ethics hotline at (800) 443 0463 - [www.archcare.ethicspoint.com](http://www.archcare.ethicspoint.com) (which is available 24 hours a day, 7 days a week.) The reports can be submitted online as well at [www.archcare.ethicspoint.com](http://www.archcare.ethicspoint.com) Any workforce member who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation and intimidation for coming forward with such information both under our internal Compliance Program policies and procedures and Federal and State law. ArchCare and its affiliated entities will not retaliate or permit retaliation against employees or others for reporting potentially unethical or illegal conduct in good faith. See Whistleblower Protection Policy ([Compliance and Ethics Program, Reporting Compliance Matters; Whistleblower/Non-Retaliation/Non-Intimidation Policy for Good Faith Participation in the Compliance Program, System-Wide](#)).

ArchCare is committed to investigating any suspicions of fraud, waste, or abuse swiftly and requires all workforce members to assist in such investigations. Corrective action will be promptly and thoroughly implemented, as necessary and appropriate. Failure to report or assist in an investigation or resolution of fraud and abuse is a breach of the workforce member's obligations to ArchCare and may result in disciplinary action, up to, and including termination of employment or affiliation with ArchCare.

ArchCare educates its workforce members on the importance of this policy on a periodic basis. See Corporate Compliance and Ethics Program Training & Education policy [Compliance and Ethics Program, Compliance Program Training & Education, System-Wide](#).

#### **RELATED DOCUMENTS:**

Other Compliance Program Policies are listed below:

[Compliance and Ethics Program, Code of Conduct](#)  
[Compliance and Ethics Program, Compliance Program Charter](#)  
[Compliance and Ethics Program, Compliance Program Files, System-Wide](#)  
[Compliance and Ethics Program, Conflict of Interest, System-Wide](#)  
[Compliance and Ethics Program, Reporting Compliance Matters; Whistleblower/Non-Retaliation/Non-Intimidation Policy for Good Faith Participation in the Compliance Program \(System-Wide\)](#)  
[Compliance and Ethics Program, Discipline Policy, System-Wide](#)  
[Compliance and Ethics Program, Employee Reviews, System-Wide](#)  
[Compliance and Ethics Program, Gifts, System-Wide](#)  
[Compliance and Ethics Program, Corrective Action and Response to Detected Offenses, System-Wide](#)  
[Compliance and Ethics Program, Risk Assessment, Monitoring and Reviewing, System-Wide](#)  
[Compliance and Ethics Program, Record Retention & Document Destruction, System-Wide](#)  
[Compliance and Ethics Program, Sanction Screening, System-Wide](#)  
[Compliance and Ethics Program, Vendor Deficit Reduction Compliance Education, System-Wide](#)

#### **REVISION HISTORY:**

Date	Change/Note
4/23/2025	Annual review and update of the policies
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
08/2021	Revised definition of workforce; added language regarding anonymous reporting and investigations.
10/1/2010	New policy providing an overview and a roadmap to the other compliance program policies.

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

**SUBJECT:** Compliance and Ethics Program, Discipline Policy, System-Wide

**ORIGINATING DEPARTMENT:** Compliance

**EFFECTIVE DATE:** September 9, 2007

**BOARD AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE:**  
5/14/2025

**MOST RECENT REVIEW/REVISION DATE:** 4/23/25

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**PURPOSE:** To address the disciplinary requirements, associate with non-compliance with ArchCare's Code of Conduct, Policies and Procedures related to the Compliance Program and detection, prevention and remediation of Fraud, Waste and Abuse.

**ENTITIES AFFECTED:** All ArchCare-sponsored entities.

**SCOPE:** This policy applies to care members of ArchCare and its affiliated entities. This policy applies to the workforce<sup>3</sup> of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors<sup>4</sup> who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

**POLICY:** All ArchCare workforce members are expected to adhere to the Code of Conduct, the Compliance and Ethics Program, and applicable ArchCare compliance

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<sup>3</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

<sup>4</sup> This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

policies and procedures. If the Chief Compliance Officer concludes, after an appropriate investigation, that there has been a violation, appropriate discipline may be imposed by the SVP, Human Resources as part of a corrective action plan. All ArchCare Entities shall implement disciplinary action upon care members in response to compliance violations on a fair, equitable and prompt basis, regardless of title or position.

Disciplinary action will be imposed for actions including, but not limited to, the following:

- failing to report suspected problems,
- authorizing or participating in noncompliant behavior;
- encouraging, directing, facilitating, or permitting either actively or passively non-compliant behavior;
- refusing to cooperate in the investigation of a potential violation;
- failure to assist in the resolution of compliance issues; and/or
- intimidating or retaliating against an individual for good faith reporting of a compliance violation or other good faith participation in the Compliance and Ethics Program.

#### **PROCEDURE:**

1. The Chief Compliance Officer and the SVP, Human Resources are responsible for assuring that disciplinary actions related to noncompliance with the law, regulations, and Compliance Program, including the Code of Conduct, are consistent with actions taken in similar instances of noncompliance. The Chief Compliance Officer shall focus on the compliance aspect, ensuring the violation is investigated and appropriate action is taken to prevent recurrence. The SVP, Human Resources shall oversee the personnel aspects, ensuring disciplinary actions are consistent with company policies and procedures.

2. In recommending appropriate sanctions to the SVP, Human Resources, the Chief Compliance Officer, or his or her designee, should consider:

- a. the nature of the violation;
- b. the time period affected;
- c. the nature and extent of a resulting government overpayment, if any;
- d. whether the violation was committed intentionally, recklessly, negligently, or mistakenly;

- e. whether the individual has committed any other violations in the past;
- f. whether the individual self-reported his or her misconduct;
- g. whether (and the extent to which) the individual cooperated in connection with the investigation of the misconduct;
- h. the impact of the problem or incident on the quality of care provided to ArchCare residents or patients;
- i. the nature and extent of potential criminal, civil or administrative liability of individuals or ArchCare;
- j. an individual's prior employment or other affiliation history with ArchCare;
- k. an entity's affiliation history with ArchCare;
- l. whether the matter at issue had been the subject of prior compliance training at or required by ArchCare;
- m. the extent to which the problem or incident reflects a systemic or departmental failure to adhere to the Compliance and Ethics Program.

ArchCare shall apply progressive discipline consistent with the violation and consistent with HR policy. The nature of the sanction will depend upon the nature of the individual's or entity's relationship with ArchCare and the nature of the violation:

- a. All care members may receive discipline which may include, but is not necessarily limited to verbal warnings, written warnings and suspension;
  - b. Employees may be subject to termination from employment;
  - c. interns, students, and volunteers may be subject to a termination of the relationship;
  - d. contractors may be subject to a termination of their contractual relationships with ArchCare; and
  - e. governing body members may be subject to a termination of their appointment to the relevant governing body.
  - f. Clinicians may also be subject to suspension of billing for their services.
  - g. ArchCare may also take other appropriate action, in its discretion.
3. Care members will be given an opportunity to review and respond to relevant evidence prior to any disciplinary action being taken.
  4. The responsibility of determining the final decision regarding sanctions to be levied rests with the SVP, Human Resources, taking into account the opinion of the Chief



Compliance Officer regarding the extent and severity of the violation. If the Chief Compliance Officer believes that the sanctions to be levied for compliance or compliance program violations in a particular circumstance are not consistent with actions taken in similar instances of non-compliance, the Chief Compliance Officer shall report such opinion to the President and CEO and the Chair, Audit, Risk, and Compliance Committee. The final determination may take into account existing contractual or other legal obligations affecting the individual or entity. Neither this Discipline Policy, nor any element of the Compliance and Ethics Program, nor any document pertaining to the Compliance and Ethics Program, shall create or effect any contract rights that may exist between a person or entity employed or retained by ArchCare.

5. The ArchCare SVP, Human Resources Officer, shall ensure that a record of any sanction imposed on an employee under the Compliance and Ethics Program is maintained in the individual's personnel record. The Chief Compliance Officer shall ensure that a record of any sanction imposed on an employee under the Compliance and Ethics Program is maintained in the Compliance and Ethics Program Files.

6. The individual responsible for provider credentialing for any ArchCare entity shall ensure that a record of any sanction imposed on a Contractor under the Compliance and Ethics Program is maintained in the Compliance and Ethics Program Files and/or in the designated contractor's record.

7. The head of the relevant program or facility shall ensure that a record is retained of any sanction imposed on care member or anyone affiliated with ArchCare and that the record is shared with the designated Compliance Officer or Compliance Liaison of that program or facility.

#### **REVISION HISTORY:**

Date	Note/Change
4/23/2025	Revised responsibility of determining sanctions: responsibility of HR in consultation with Chief Compliance Officer.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, formatting was changed.
8/2022	Replaced Compliance Program with Compliance and Ethics Program throughout
8/2021	Reorganized document to include a "procedures" section. Defined care members consistent with charter. Added ArchCare's expectations as to care member's adherence to the Compliance Program; Expanded actions subject to discipline; expanded factors considered in determining disciplinary action;

	expanded potential disciplinary actions. Added that care members will be given an opportunity to review and respond to relevant evidence prior to any disciplinary action being taken.
11/2019	Clarified that sanctions will be imposed on all those affiliated with ArchCare, including ArchCare workforce, contractors, governing body members, etc.), not simply employees.
2/2018	Added second sentence to #4, incorporating ramifications should employee fail to satisfactorily implement a corrective action.
6/2016	Clarified that Chief Compliance Officer has an approval role in determining discipline for compliance infractions;
6/2014	Changes per OMIG evaluation tool: updated to note that sanctions will be imposed upon Designated Contractors in response to compliance violations;
1/2011	Changes per annual review, audit, and OMIG evaluation tool: clarified that discipline would be implemented regardless of title or position and that sanctions could include termination;
9/6/2007	New policy

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Employee Reviews, System-Wide

ORIGINATING DEPARTMENT: Compliance

EFFECTIVE DATE: March 1, 2011

BOARD AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE:  
5/14/2025

LAST PERIODIC REVIEW DATE: 4/23/25

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**ENTITIES AFFECTED:** All ArchCare-sponsored entities.

**SCOPE:** This policy applies to the workforce<sup>5</sup> of ArchCare and its affiliated entities. Specifically, for the purposes of this policy ArchCare “workforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students.

**POLICY:** Reviews for each employee shall include an assessment of awareness of and adherence to the Compliance and Ethics Program, including, but not limited to, compliance with internal compliance policies, the Code of Conduct and applicable laws, rules and regulations.

**PROCEDURE:**

1. Individuals conducting annual reviews of ArchCare employees shall address employee awareness of and adherence to the Compliance and Ethics Program during such reviews.
2. Employee reviews may include discussion of employee awareness of their responsibilities under the Compliance and Ethics Program, including, for example, ArchCare’s expectation that employees report compliance concerns or issues, cooperate with investigations and cooperate with the resolution of compliance

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<sup>5</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

issues. An employee's adherence to the Compliance and Ethics Program may be noted in the employee's written performance appraisal.

3. Employee reviews may also include discussion of whether any compliance issues have arisen during the review period as to the employee and if so, whether such issues resulted in or should result in a reprimand/warning, suspension, discharge, termination or other sanction and/or corrective action. A record of any sanction imposed under the Compliance and Ethics Program shall be maintained in the Compliance Officer's file and/or in the employee's personnel file and may be noted in the employee's written performance appraisal.
4. The supervisor or manager conducting the employee review will promptly report to the appropriate Compliance Officer any matters raised during the review that present potential compliance concerns.

**REVISION HISTORY:**

Date	Note/Change
4/23/25	Annual review and update of the policies.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	Replaced Compliance Program with Compliance and Ethics Program
1/2011	Changes per annual review
8/2011	Added to sections 1 and 2 language regarding assessment of the employee's awareness of the compliance program, as well as adherence.
9/6/2007	Original Policy

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

**SUBJECT:** Compliance and Ethics Program, Compliance and Ethics Program Files, System-Wide

**ORIGINATING DEPARTMENT:** Compliance

**EFFECTIVE DATE:** February 15, 2011

**BOARD AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE:**  
5/14/2025

**MOST RECENT REVIEW/REVISION DATE:** 4/23/25

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**PURPOSE:** To establish a routine documentation system for compliance documents.

**ENTITIES AFFECTED:** All ArchCare-sponsored entities.

**SCOPE:** This policy applies to the workforce<sup>6</sup> of ArchCare and its affiliated entities. Specifically, ArchCare “workforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term “workforce” also applies to contractors, subcontractors, agents and independent contractors<sup>7</sup> who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

**POLICY:** ArchCare maintains uniform filing and documentation systems for compliance-related documents and other materials, which must be kept in accordance with the document retention policy

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<sup>6</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

<sup>7</sup> This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

## **PROCEDURE:**

1. The Compliance Liaison shall establish and maintain (or require appropriate departments to establish and maintain) uniform filing and documentation systems in secure locations.
2. All documents that the Compliance Liaisons reasonably believe to be subject to the attorney-client privilege shall be filed separately from other documents and maintained in a locked file. Access to such privileged files shall be restricted to those officers or other agents of ArchCare who have a need to know the contents of these files.
3. The Compliance Liaisons and/or appropriate department heads, supervisors and managers, shall appropriately document and file the following information:
  - a. Corporate/compliance education or IT department will retain the evidence of completion of corporate/compliance orientation and reconciliation on the e-Learning system.
  - b. Corporate/Compliance education or IT department shall retain documentation pertaining to compliance training programs, including the date of the training program, the presenter(s), a brief description of the presentation, presentation materials and sign-in sheets. In addition, should maintain the annual Training Plan.
  - c. ArchCare's Chief Compliance Officer shall retain evidence of Compliance Liaisons' appointment and quarterly reports to the Board.
  - d. ArchCare, Human Resources will retain documentation relating to background checks of new employees and results of monthly sanction screenings, and credential screening of professional staff. Please see Sanction Screening Policy regarding documentation for monthly sanction screenings of agency staff, credentialed staff, vendors, and other non-employee entities.
  - e. ArchCare, Human Resources will retain documentation relating to disciplinary actions taken against employees resulting from violations of the Compliance and Ethics Program.
  - f. The Chief Compliance Officer and Compliance Liaisons shall retain Compliance Committee agendas and minutes.

- g. The Chief Compliance Officer shall retain the Code of Conduct, Compliance Charters and Compliance policies and procedures, indicating dates approved, reviewed, revised and effective. The Chief Compliance Officer shall maintain evidence of annual reviews and annual distribution to staff.
  - h. The Chief Compliance Officer or Compliance Liaisons, depending upon the responsibilities in a particular case, shall maintain the following in subsections (h) through (l), including documentation of audit findings, reports or complaints made to the Compliance Officers or the Hotline. Reports to management and corrective action plans prepared as a result of audit findings, reports or complaints made to the Compliance Liaisons also should be maintained in the Compliance Liaisons' files.
  - i. Documentation of annual compliance work plans and auditing and monitoring conducted in furtherance of the Compliance and Ethics Program.
  - j. Documentation of reports made to the Audit, Risk and Compliance Committee of the ArchCare Board of Trustees or to the Boards of Managers of the Catholic Special Needs Plan, LLC or the Catholic Managed Long Term Care, Inc. on compliance.
  - k. Documents related to self-disclosures and/or overpayment reports to federal health care programs or oversight agencies (*e.g.*, OIG, OMIG, Medicare contractor).
  - l.
4. All documents related to the Compliance and Ethics Program shall be kept for ten (10) years.

**REVISION HISTORY:**

Date	Change/Note
4/23/2025	Annual review and update of the policies.
5/1/2024	Annual review and update of the policies.

5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	Changes per annual review: replaced compliance program with compliance and ethics program
8/2021	Changes per annual review
1/2011	Changes per annual review



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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Conflicts of Interest and Related Party Transactions, System-Wide

ORIGINATING DEPARTMENT: Compliance

ORIGINAL EFFECTIVE DATE: March 1, 2011

Most recent revision date: 4/23/24

Audit, Risk, and Compliance Committees Approval Date: 5/14/2025

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**PURPOSE:** The purposes of this Policy are: (1) to preserve the integrity of the decision-making process of ArchCare; (2) to prevent the intentional or inadvertent participation in the decision-making process by persons who have a conflict of interest; (3) to promote fairness and openness in the process by which conflicts of interest are disclosed and managed; (4) to assure compliance with applicable laws that govern transactions in which there are conflicts of interest and (5) to ensure that Personnel act in ArchCare's best interest and comply with applicable legal requirements.

This Policy is designed to be a guide for Personnel who may find themselves in a position where their personal interests could cause, or be perceived to cause, a conflict with the interests of ArchCare. It is important that any actual, potential or perceived conflict of interest be avoided. Even the appearance of illegality, impropriety, or a conflict of interest can be detrimental to ArchCare, and therefore should be avoided.

**ENTITIES AFFECTED:** All ArchCare-sponsored entities.

**SCOPE:** This Policy is applicable to Trustees, Officers and Key Persons (as those terms are defined below; hereinafter collectively referred to in this Policy as “**Personnel**”) of Catholic Health Care System dba ArchCare and Affiliated Entities (“**ArchCare**”).

**ENTITIES AFFECTED:** All ArchCare-sponsored entities

### DEFINITIONS:

5. **Affiliate.** An entity controlled by Catholic Health Care System dba ArchCare or in control of Catholic Health Care System dba ArchCare.
6. **Disclosable Interests.** Personnel have a Disclosable Interest if he/she, or a Relative:

- a. Has any financial interest in a Vendor (as such term is defined below);
- b. Is a member, owner, director, trustee or officer of a Vendor;
- c. Has a contractual or employment relationship with a Vendor;
- d. Accepts gifts, entertainment or other favors from a Vendor, competitor or entity with which ArchCare does business, intends to do business or competes;
- e. Represents ArchCare in any matter in which the person has a personal interest (financial or otherwise);
- f. Uses, or has the opportunity to use, knowledge about ArchCare for personal gain, profit or advantage;
- g. Has any family or business relationship with another Trustee, Officer or Key Person. A business relationship includes where: (i) one person is employed by the other in a sole proprietorship or by an organization with which the other is associated as a trustee, director, officer, or greater-than-35% owner, even if that organization is tax-exempt; (ii) one person is transacting business with the other (other than in the ordinary course of either party's business on the same terms as are generally offered to the public), directly or indirectly, in one or more contracts of sale, lease, license, loan, performance of services, or other transaction involving transfers of cash or property valued in excess of \$10,000 in the aggregate during ArchCare's tax year; and (iii) the two persons are each a director, trustee, officer, or greater than 10% owner in the same business or investment entity (but not in the same tax-exempt organization);
- h. Has a financial or other interest, either directly or indirectly through a Relative, in an organization that provides grants to conduct research or other projects in association with ArchCare;
- i. Engages in, or intends to engage in, a Related Party Transaction (as that term is defined below).

Note, however, that *De Minimis* transactions and Ordinary Course of Business transactions (as defined herein), are not covered by this Policy. Even in such cases, however, the affected party may not intervene or seek to influence the person tasked with making the decision or reviewing the transaction. Further, the person tasked with making the decision or reviewing the transaction should not consider or be influenced by the affected party's involvement in decisions or matters that may affect the decision-maker/reviewer.

7. **De Minimis Transaction.** A “*De Minimis*” transaction for purposes of this Policy is one that is immaterial or insignificant to ArchCare, taking into account all relevant factors, including but not limited to: (i) ArchCare’s overall business or financial operations; (ii) any impact the transaction might have on the quality of care, treatment or services provided to our residents, and/or (iii) the size and scope of the particular transaction.
8. **Improperly Influence.** “Improperly Influence” means coercing, manipulating, misleading, or fraudulently influencing the decision-making when a Trustee, Officer, or Key Person knew or should have known that their action, if successful, could result in the outcome which they could not deliberate or vote on directly.
9. **Key Person.** Someone who is not an officer or director, whether or not employed by ArchCare, who (i) has responsibilities or exercises powers or influence over ArchCare as a whole similar to the responsibilities, powers, or influence of directors and officers; (ii) manages ArchCare, or a segment of ArchCare that represents a substantial portion of the activities, assets, income or expenses of the corporation; or (iii) alone or with others controls or determines a substantial portion of ArchCare’s capital expenditures or operating budget. For purposes of this Policy, the following are ArchCare Key Persons: all individuals reporting directly to the President & CEO of ArchCare and the Chief Information Officer. For the ArchCare Affiliates, Key Persons are all individuals reporting directly to the Administrator or Executive Director of the program or facility.
10. **Officer.** “Officer” means those individuals designated as officers in the by-laws of ArchCare and those who are otherwise appointed as officers of ArchCare in accordance with ArchCare’s by-laws.
11. **Ordinary Course of Business Transaction.** An “Ordinary Course of Business” transaction is one that is consistent either with ArchCare’s consistently applied past practices in similar transactions or with common practices in the industry in which ArchCare operates. Examples of Ordinary Course of Business transactions include, but are not limited to: (i) a nonprofit entity that uses the local electric utility for its electrical service and supply, and a 35% shareholder of the local electric utility is a board member; (ii) where the general counsel of a health system has a written, established, and enforced policy for the selection, retention, evaluation and payment of outside counsel, and a board member is a partner of, and has a greater than 5% share in, one of the firms retained by the general counsel; and (iii) a grandson of a board member has just graduated from a university nursing school. He applies for and is selected by the facility’s nursing department for a tuition repayment benefit and will receive a salary and overtime, consistent with the facility’s written policy regarding recruitment of new nursing graduates.

## **12. Related Party.**

- a. any Trustee, Officer or Key Person of ArchCare;
- b. any Relative of such individual; or
- c. any entity in which such individual or Relative has a 35% or greater ownership or beneficial interest or, in the case of a partnership or professional corporation, a direct or indirect ownership interest in excess of 5%

**13. Related Party Transactions.** Any transaction, agreement or other arrangement in which a Related Party has a financial interest and in which ArchCare is a participant except for (i) the transaction or the Related Party's financial interest in the transaction is *De Minimis*; (ii) the transaction would not customarily be reviewed by the board or boards of similar organizations in the Ordinary Course of Business and are available to others on similar terms, as determined by counsel and approved by the Audit, Risk, and Compliance Committee ("Committee") of the Board of Trustees; or (iii) the transaction constitutes a benefit provided to a related party solely as a member of a class of the beneficiaries that ArchCare intends to benefit as part of the accomplishment of its mission which benefit is available to all similarly situated members of the same class on the same terms.

**14. Relative.** An individual's spouse or domestic partner (as defined in Public Health Law §2994-a), ancestors, brothers and sisters (whether whole or half-blood), children (whether natural or adopted), grandchildren, great-grandchildren, and spouses or domestic partners of the individual's brothers, sisters, children, grandchildren, great-grandchildren.

**15. Trustee.** "Trustee" means any member of the governing board of ArchCare, whether designated as director, trustee, manager, governor, or by any other title.

**16. Vendor.** The term "Vendor" includes all vendors, suppliers, consultants, and other third parties (including, but not limited to, pharmaceutical manufacturers) seeking to do, or currently engaged in, business with ArchCare.

## **POLICY:**

All Personnel should engage in transactions without any appearance of favor or preference based on personal considerations. Personnel must, at all times, exercise their best skill, care and judgment for the benefit of ArchCare and must refrain from being influenced by personal considerations of any kind in the performance of their duties. Whenever a conflict of interest – or even a possible conflict of interest – exists, it must be

fully disclosed in accordance with the procedures set forth in this Policy. The Personnel involved may then be required to refrain from participating in the consideration or determination of the transaction.

All Personnel will be expected to read and understand this Policy and to review it periodically in order to be alert to situations which could pose an actual or potential conflict of interest so that such conflict can be properly reported in accordance with the procedures outlined in this Policy and, if applicable, reported to the public on IRS Form 990. Failure to adhere to this Policy will be considered a breach of the Personnel's obligation to ArchCare, and may result in disciplinary action.

## **OVERSIGHT OF THIS POLICY**

The adoption, implementation of and compliance with this Policy is overseen by the Audit, Risk, and Compliance Committee of the Board of Trustees. The Committee may, in its discretion, authorize certain functions relating to the implementation of, and compliance with, this Policy to be performed by one or more ArchCare employees, but the Committee shall, at all times, retain overall responsibility for all aspects of the oversight of this Policy.

The Audit, Risk, and Compliance Committee has authorized ArchCare's Chief Compliance Officer to provide it with assistance in the implementation of, and compliance with, this Policy. Such assistance may include having the Chief Compliance Officer: (1) gather the Conflict of Interest Disclosure Statements; (2) track the successful completion of the Statements; (3) transmit the Statements to the Chair of the Audit, Risk, and Compliance Committee for each ArchCare Entity, or, if the Entity has no Audit, Risk and Compliance Committee, directly to the Chair of the Board of the Entity; and (4) assist the Committees or Boards in organizing the Statements for review.

## **PROCEDURES**

### **1. Disclosure Requirements.**

All Personnel who have a Disclosable Interest must disclose that interest and all material facts related thereto in writing by completing a Conflict of Interest Disclosure Statement, as provided below. If the Personnel is in doubt as to whether they have a disclosable interest, he/she should err on the side of caution and complete a Conflict of Interest Disclosure Statement.

- a. Annual Conflict of Interest Disclosure Statements. All Trustees, Officers and Key Persons will, at least annually, file a written Conflict of Interest Disclosure

Statement with the Chief Compliance Officer who will provide copies of all completed Statements to the Chair of the appropriate Committee or Board.

For Trustees, the Conflict of Interest Disclosure Statement will specifically include a statement identifying, to the best of the Trustee's knowledge, any entity of which he or she is an officer, director, trustee, member, owner (either as a sole proprietor or a partner), or employee and with which ArchCare has a relationship, and any transaction in which ArchCare is a participant and in which the Trustee might have a Disclosable Interest.

- b. Continuing Obligation to Update Annual Written Conflict of Interest Disclosure Statement. Every Trustee, Officer and Key Person has an affirmative obligation to update his or her annual written Conflict of Interest Disclosure Statement whenever there are new or changed facts or circumstances that create a Disclosable Interest. Such disclosure must be made (a) prior to voting on or otherwise discharging his or her duties with respect to any matter involving the conflict which comes before the Board and/or a Committee; (b) prior to entering into any contract or transaction involving ArchCare; and/or (c) as soon as possible after learning of a conflict of interest in any other context. All such Statements are to be filed with the Chief Compliance Officer who will provide copies of all completed Statements to the Chair of the appropriate Committee or Board.
- c. Prior to the Initial Election of a Trustee. Prior to the initial election of any Trustee, the individual proposed for a Trustee position shall complete, sign and submit to the Secretary of the Corporation a written Conflict of Interest Disclosure Statement identifying, to the best of the proposed Trustee's knowledge, any entity of which he or she is an officer, director, trustee, member, owner (either as a sole proprietor or a partner), or employee and with which ArchCare has a relationship, and any transaction in which ArchCare is a participant and in which the proposed Trustee might have a Disclosable Conflict of Interest. All such Statements will be filed with the Chief Compliance Officer who will provide copies of each completed Statement to the Chair of the appropriate Committee or Board.
- d. Additional Disclosure Requirements to the Board of Trustees. If, during the course of a Board meeting, discussion, or deliberation, any actual or potential conflict of interest becomes apparent to a Board member, the Board member must disclose such actual or potential conflict to the Board. If another Board member becomes aware of any actual or potential conflict of interest, he or she

shall disclose such conflict if the conflicted Board member is absent. In both cases, such disclosure shall be made a matter of record.

## **17. Action Following Disclosure**

The Committee or Board will conduct a full review of all matters that raise an actual or potential conflict of interest, or that create the appearance of an actual or potential conflict of interest. In so doing, the Committee or Board will:

- a. consider all relevant facts and circumstances involved in the matter, and in particular, what is fair, reasonable and in the best interests of ArchCare and the individuals it serves;
- b. exclude the affected individual(s) from being present at or participating in the deliberations or voting on the matter;
- c. prohibit the affected individual(s) from any attempt to Improperly Influence the deliberations or voting on the matter; and
- d. permit the affected individual(s), upon request of the Committee or Board, to present information as background or answer questions concerning the matter at a meeting prior to commencement of deliberations or voting on the matter.

**18. Additional Special Rules for Related Party Transactions.** In addition to the general considerations outlined above, all Related Party Transactions are subject to the following additional special rules:

- a. ArchCare may not enter into a Related Party Transaction unless the transaction is determined by the Committee or the Board to be fair, reasonable and in ArchCare's best interest at the time of the determination;
- b. In considering the Related Party Transaction, the Committee or the Board shall ensure that any Board Member, Officer or Key Person who has an interest in the Related Party Transaction has disclosed in good faith all material facts concerning such interest; and
- c. No Related Party may participate in the deliberations or voting relating to any Related Party Transaction in which he or she has an interest. However, the Committee or the Board may request that a Related Party present information

as background or answer questions concerning a Related Party Transaction at a meeting prior to the commencement of deliberations or voting relating thereto.

**19.** With respect to any Related Party Transaction involving ArchCare and in which a Related Party has a substantial financial interest, the following shall also apply:

Prior to entering into the transaction, the Committee or the Board shall consider alternative transactions to the extent available;

The transaction must be approved by not less than a majority vote of the members present at the meeting; and

The Committee will contemporaneously document in written minutes the basis for its approval or disapproval, including its consideration of any alternative transactions.

The conflicted Trustee may not be counted in determining the presence of a quorum at a meeting of the Board or the Committee, as applicable, which deliberates and votes on such Related Party Transaction.

**20. Corrective Action.** If the Committee determines that a potential or actual conflict of interest exists, the following corrective actions must be taken to protect ArchCare's best interests:

a. Fair and Reasonable Transactions. The Committee will determine whether the transaction is fair and reasonable to ArchCare and whether a transaction furthers ArchCare's charitable purposes and does not result in inurement or impermissible private benefit. If the Committee decides to establish a relationship with either a vendor or with a Board member with which there is a conflict of interest, they may:

Instruct that ArchCare's competitive bidding process be utilized without the involvement of the conflicted Board member(s);

Obtain an independent evaluation to assess the fair market value of the transaction; and

Obtain guidance from outside counsel to ensure that the transaction complies with applicable laws, rules and regulations, including those governing charitable institutions and to understand the IRS Form 990 disclosure implications.



- b. Approval by Affiliate's Governing Board. Regarding any conflict of interest issue addressed by the Committee or the Board involving an Affiliate, the Committee or the Board will report its determination and recommendation to the respective Affiliate's Governing Board who, acting through its members, will make a determination whether to approve or disapprove the Committee's determination and recommendation.

## **21. Documentation.**

The Committee or Board will contemporaneously document in writing in appropriate minutes of any meeting at which the matter is deliberated or voted upon all deliberations and determinations relating thereto, including, at a minimum, a summary of the matter, a summary of the deliberations, consideration of any alternatives, who is present at the meeting(s), the vote and the basis for the determination, including, but not necessarily limited to, whether the matter is as fair and reasonable to ArchCare as would otherwise then be obtainable by ArchCare.

## **OTHER MATTERS PERTAINING TO CONFLICTS OF INTEREST:**

### **1. Loans To Trustees and Officers: Per Se Conflicts Of Interest.**

No loans other than through the purchase of bonds, debentures, or similar obligations of the type customarily sold in public offerings, or through ordinary deposit of funds in a bank, shall be made by ArchCare to its Trustees or Officers, or to any other corporation, firm, association, or other entity in which one or more of its Trustees or Officers are trustees, directors or officers or hold a substantial financial interest.

### **22. Ban on Private Inurement.**

ArchCare shall not engage in a transaction or enter into a compensation arrangement with Trustees, Officers, or Key Persons (including senior staff members, or others in a position to exercise substantial influence over the affairs of ArchCare) that provides an economic benefit to such person in excess of the consideration or services that ArchCare receives in return. All forms of compensation shall be considered in determining if an excess benefit has been conferred, including salary, fees, bonuses, severance payments actually made, medical insurance, pension plans and other benefits.

### **23. Conflicts of Interest in Compensation Decisions**

No individual who directly or indirectly receives compensation from ArchCare or its Affiliated Entities shall make or be involved in making compensation decisions for ArchCare pertaining to his or her own compensation and may not be present at or

otherwise participate in Board or Committee deliberation or vote, except to respond to requests for information, background or response to questions prior to beginning deliberations or voting.

## **24. Compliance with Gift and Fundraising Policies**

All Personnel must comply with applicable ArchCare gift and fundraising policies. These policies strictly prohibit Personnel from soliciting any gift or benefit, either individually or on behalf of ArchCare, other than for official fund raising events. In addition, Personnel may not offer, pay or receive any gifts or benefits to or from any person or entity: (i) that makes a health care related referral to us, (ii) to which we make health care related referrals, or (iii) with which we do business, under circumstances where the gift or benefit is offered, paid or received with a purpose of inducing or rewarding referrals of health care goods, items or services, or other business between the parties.

## **VIOLATIONS OF THE POLICY**

If the Audit, Risk, and Compliance Committee or the Board has reasonable cause to believe any Trustee, Officer or Key Person has failed to disclose actual or possible conflicts of interest, it shall inform the Personnel of the basis for such belief and afford him/her an opportunity to explain the alleged failure to disclose. If there is reasonable cause to believe that a member of the Board has violated this policy, that member will recuse him or herself from any consideration or determination of the matter. If, after hearing the Personnel's response and making further investigation as warranted by the circumstances, the Committee or the Board determines that the Personnel has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

The Compliance Officer, on behalf of the Secretary of the Corporation, will ensure that all Personnel file Conflict of Interest Disclosure Statements, or follow-up to make sure they do, in accordance with this Policy. If Personnel fail to comply with the Policy's disclosure requirements, the Compliance Officer will report such failure to the Committee or the Board, which shall recommend appropriate corrective action.

**Failure to disclose adequately a potential or actual conflict of interest shall constitute cause for removal from the Board and/or Committee.**

**REVISION HISTORY:**

Date	Change/Note
4/23/2024	Annual review and update of the policy.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review to align with the new OMIG Guidance. In addition, made formatting changes.
8/2022	Changed to Audit, Risk, and Compliance Committees Approval and replaced Compliance Program with Compliance and Ethics Program
8/2021	Expanded the Purpose, Definitions and Procedures sections, consistent with Not for Profit Corporation Law; added Scope, Policy and Oversight section.
11/2019	Changed definition of Key Person to match updates to Non-Profit Revitalization Act.
12/2017	In response to CSNP DFS audit, added footnote regarding electronic signatures
4/2014	Modified to comply with Non-Profit Revitalization Act.
3/2014	Clarified in a footnote that electronic signatures as well as “wet” signatures on conflict of interest statements are acceptable under this policy.
6/2013	Added role of Conflicts Management Committee to the end of paragraph 7. The Committee determines whether further steps must be taken to manage the potential conflicts disclosed. Also added responsibilities of compliance officers in collecting the conflict of interest statements.
1/2011	Changes per annual review
9/6/2007	New Document

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Investigating Compliance Matters, System-Wide

ORIGINATING DEPARTMENT: Compliance

APPROVAL DATE: 09/21/2022

MOST RECENT REVIEW/REVISION DATE: 4/23/2025

AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE: 5/14/2025

Version: 10

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**PURPOSE/POLICY:** To be effective and to combat fraud, waste and abuse (FWA) in the course of operations, a Compliance and Ethics Program must institute procedures for investigating compliance issues and implementing appropriate corrective action. Therefore, ArchCare has established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, and correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with federal health care programs requirements (*e.g.*, Medicare and Medicaid). Below are the procedures that ArchCare has adopted as to investigations. See [Compliance and Ethics Program, Corrective Action and Response to Detected Offenses, System-Wide](#) for information related to corrective actions.

**ENTITIES AFFECTED** All ArchCare-sponsored entities.

**SCOPE:** this policy applies to the workforce<sup>8</sup> of ArchCare and its affiliated entities. Specifically, ArchCare “workforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term “workforce” also applies to contractors, subcontractors, agents and

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<sup>8</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

independent contractors<sup>9</sup> who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

## **PROCEDURES:**

### **25. Investigation - Generally.**

A compliance problem may be uncovered as the result of a report to the Chief Compliance Officer, Compliance Liaison or Compliance Hotline, an internal compliance assurance review, the review of a new regulation or governmental fraud alert, or from another source. Such problems might include, any of the following: evidence that ArchCare is billing for services that were not performed or ordered; that medical documentation does not adequately support the billing codes selected; or suspect financial relationships with other providers who have a referral relationship with ArchCare.

Upon receiving a report or otherwise learning of a possible compliance issue, the Chief Compliance Officer will bring such report to the attention of the applicable ArchCare Entity Compliance Officer or Compliance Liaison and the applicable operational Compliance Committee.<sup>10</sup> Assisted by such personnel, the Chief Compliance Officer or a designee(s) will promptly conduct an investigation and take all necessary and appropriate actions. Such investigations may be undertaken under the supervision and direction of outside counsel, as necessary and appropriate. Preliminary information may justify informing the President and CEO and Boards of Trustees of a potential compliance matter prior to (or during) investigation by the Compliance Officer.

All affected individuals are expected to cooperate in all compliance investigation. Failure to cooperate can result in discipline up to and including termination.

Depending on the nature of the potential compliance issue, an investigation may include interviews with care members, documentation reviews and a root cause analysis. The objective of such an investigation will be to determine whether, first, a compliance issue exists or there has been a violation of the Compliance and Ethics Program (including ArchCare's compliance policies and procedures, the Code of Conduct or applicable laws, regulations or other requirements. If an issue or violation does exist, then the

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<sup>9</sup> This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

<sup>10</sup> Certain referrals are investigated by the Special Investigation Unit, that decision is made by the Chief Compliance officer.

investigation will attempt to determine its root cause so that appropriate and effective corrective action may be instituted.

## **26. Initial Assessment of Reports.**

The report will be assessed by the relevant Compliance Officer or Compliance Liaison and the Chief Compliance Officer in consultation with appropriate senior management to determine whether it is actionable and whether it should be referred.

Examples of non-actionable reports include:

- Reports that do not provide enough information
- Reports that do not, as alleged, present compliance concerns
- Reports made in bad faith

Whenever possible, the Chief Compliance Officer or the applicable Compliance Officer or Compliance Liaison shall provide the individual submitting a report that is non-actionable with information on why the report cannot be acted upon.<sup>11</sup>

Reports that will be referred are those for which there is a dedicated policy or procedure or complaints that are more appropriately handled through another process. For example:

- Reports of patient abuse or neglect shall be referred to an independent reviewer who will review the allegation, conduct an investigation of the allegation, draft a report of the results of the investigation and provide to the Chief Compliance Officer, and create a corrective action plan, if necessary, for the facility or program to follow;
- Reports regarding customer service shall be referred to the appropriate facility or program;
- Reports regarding employee harassment or discrimination or compliance with personnel policies shall be referred to Human Resources

Programs, facilities, and Human Resources shall provide the Chief Compliance Officer with information on the disposition of reports that have been referred.

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<sup>11</sup> Compliance team will reach out to the reporter for additional information, if possible. If the reporter fails to respond or provide additional information, the matter will be closed.

On Ethics Point, “first outcome” will be “referred”; “second outcome” will be substantiated, unsubstantiated or partially substantiated. “Action taken” will be the action taken as the result of the investigation. If “unsubstantiated” “action taken” is “no action necessary.”

On Ethics Point, for non-actionable reports or reports for which the reporter is given information on the appropriate process to follow “primary outcome” will be changed to “insufficient information” and “Action Taken” will be “No Action Necessary” before the status is marked “closed.”

## **27. Communicating with Reporters Who Identify Themselves.**

The ArchCare Chief Compliance Officer or the person to whom the call report has been assigned will acknowledge receipt of the report by responding to the caller promptly.

After the issue has been investigated, if applicable, and the non-compliance has been remedied or a corrective action plan has been created, the ArchCare Chief Compliance Officer will report to the reporter that the investigation is completed and will report the findings and explain how the problem has been remedied, if appropriate.

If applicable, the Chief Compliance Officer will contact the caller promptly, at a specified date, and ask if the caller continues to be satisfied with the manner in which the complaint was handled.

## **28. Communicating with Reporters Who do Not Identify Themselves.**

The ArchCare Chief Compliance Officer will record: (a) acknowledgment of receipt of call and (b) resolution of investigation and corrective action in response to the call, if applicable, promptly and no later than the “follow up date” on the Global Compliance system.

## **29. Investigations – Actionable Reports.**

Actionable reports typically will be investigated by the Chief Compliance Officer and other individuals selected by the Chief Compliance Officer. Interim measures may be taken to prevent retaliation or to facilitate effective investigation.

The Compliance Office is authorized full, free and unrestricted access to ArchCare records, facilities, and care members pertinent to carrying out any investigation.

- a. The purpose of the investigation is to determine if there has been an occurrence or course of fraud, abuse or other systemic noncompliance, and if so:

To determinate the nature, scope, frequency, duration and financial magnitude of the fraud, abuse or other noncompliance;

To identify the individuals who may have knowingly or inadvertently been responsible for the fraud, abuse or other noncompliance;

To develop facts so that the ArchCare Entity may:

Cease the problematic activity

Determine whether it has a repayment obligation;

Determine whether it has a disclosure obligation

Develop and implement a corrective action plan;

Take appropriate disciplinary steps against the persons responsible

Make required or appropriate reports or referrals concerning the persons responsible, such as reports to licensing authorities;

Take lawful and appropriate steps to minimize the jeopardy to ArchCare's mission, and protect itself from unwarranted civil and criminal liability; or

Take other appropriate corrective action.

b. The investigation process shall include, as applicable, but need not be limited to:

Interviewing the complainant and other persons who may have knowledge of the alleged fraud, abuse or other noncompliance;

Reviewing medical records, bills and other documents relevant to the alleged fraud, abuse or other noncompliance;

Reviewing other representative bills or claims submitted to the relevant payor; and

reviewing the applicable laws, regulations, and other documents regarding program requirements.

c. Timeliness of Investigations of Fraud, Waste, and Abuse. Investigations must be concluded within a reasonable time period after the potential offense was detected. What is considered reasonable will depend upon the circumstances of the particular instance.. Such investigations must be reported on periodically to



the relevant operational committee and to the Board or Board Committee, no less than quarterly and the committee and the Board or Board Committee should evaluate whether the timeframe of the investigation is reasonable considering the facts and circumstances, and direct that the investigation be conducted by a third party or referred to a regulatory or enforcement agency if internal resources are not sufficient to reach a conclusion within a reasonable timeframe.

- d. Preliminary Actions. If the Chief Compliance Officer believes that the presence of employees under investigation may jeopardize the integrity of an investigation, or that the allegations are of such a serious nature that, if true, the employees pose an immediate threat to the health and/or safety of ArchCare residents or personnel, the Chief Compliance Officer, in consultation with the VP, Human Resources, may recommend to the President and CEO that the employees under investigation be temporarily suspended or temporarily reassigned to another work area (subject to any rights the investigated employee may have under applicable union contracts and rules).

### **30. No Findings of Fraud, Abuse or other Noncompliance**

If at any time the Entity Compliance Officer or Compliance Liaison, in consultation with the Chief Compliance Officer, and legal counsel and the VP, Human Resources, if appropriate, concludes, based on the investigation, that the reported conduct does not constitute fraud, abuse or other noncompliance, the Compliance Officer or Compliance Liaison shall document in the Compliance records.

### **31. Reports to Management and Governing Bodies**

Reports of Hotline calls will be made to the ArchCare Executive Compliance Steering Committee, the President and CEO of ArchCare, and/or the Executive Director of the relevant ArchCare Entity, depending upon the nature of the call. Summaries of significant actions resulting from Hotline calls (written to protect the identity of the reporting individual to the extent possible and/or appropriate) shall be included in reports to the ArchCare Audit, Risk and Compliance Committee of the Board and the appropriate governing body if there is no compliance committee by the Chief Compliance Officer, the President and CEO, or the Executive Director of the Entity.

At the conclusion of the investigation, if the ArchCare Entity Compliance Officer or Compliance Liaison, in consultation with the Chief Compliance Officer, legal counsel (if involved), and the VP, Human Resources, concludes that there has been fraud, abuse or other systemic noncompliance, the Compliance Officer shall prepare a report of findings that shall include, as applicable:

- a. the reason for commencing the investigation;
- b. the investigation process;
- c. a description of the evidence of fraud, abuse or other systemic noncompliance;
- d. facts ascertained regarding the nature, scope, frequency, duration and financial magnitude of the fraud, abuse or other systemic noncompliance;
- e. the identity of person or persons who appear to have been responsible for the fraud, abuse or other systemic noncompliance, and a description of the evidence of their responsibility and intent; and
- f. recommended responses.

Reports of all such investigations shall be reported to the relevant governing body, whether the Audit Risk & Compliance Committee of the Board of Trustees, the Management Committee of the Catholic Special Needs Plan, LLC., or the Board of Managers, Catholic Managed Long Term Care, Inc.

### **32. Retention of Records of Reports and Investigations.**

The Compliance Office will maintain a log of all reports, tracking their receipt, investigation and resolution. Sufficient documentation should be maintained by the Compliance Officer on the Global Compliance Integrilink system to describe the nature, scope and outcome of any internal investigation that is undertaken. If investigation was not initiated by Global Compliance hotline, documentation should be developed on Corrective Action Plan form [Compliance and Ethics Program, Corrective Action Plan Form, System-Wide](#) and approved by Executive Director and appropriate Compliance Officer or Compliance Liaison or the Chief Compliance Officer and filed in Compliance Files.

The Compliance Office is accountable for safeguarding records and information and keeping records confidential.

### **33. Non-retaliation/Non-intimidation**

No care member will be punished for reporting what he or she reasonably believed to be a compliance issue or potential violation of the Compliance and Ethics Program. [Compliance and Ethics Program, Reporting Compliance Matters; Whistleblower/Non-retaliation/Non-Intimidation Policy for Good Faith Participation in the Compliance Program \(System Wide\).](#)

### 34. Anonymity/Confidentiality.

Compliance reports may be made anonymously, if a person chooses. If not made anonymously, the confidentiality of individuals reporting compliance issues will be maintained, except when the matter is subject to a formal disciplinary proceeding, or when it is under investigation by regulatory bodies like MFCU, OMIG, or law enforcement, or when legal proceedings require disclosure. Compliance files shall be located in a secure area to maintain appropriate confidentiality of reported information.

#### REVISION HISTORY:

Date	Change/Note
4/23/2025	Annual review and update of the policy. Specified when confidentiality of complainant cannot be maintained, consistent with OMIG program guidance.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes
8/29/2022	Annual review
8/2021	Expanded "Scope" of policy to "care members," consistent with definition in the Charter. Removed portion of "reporting" section and section on "anonymity" to Compliance Program, Reporting Compliance Matters; Non-Retaliation/Non-intimidation Policy, System-Wide Policy. Updated for compliance with Social Services Law 363-d. Incorporated sections regarding investigations from Compliance Program, Response to Detected Offenses, System-Wide Policy. Re-organization, other edits.
5/2021	Changed section 2 so that reports of patient abuse or neglect shall be referred to independent investigator who will conduct investigation and corrective action plan. Also changed how non-actionable reports are classified on Ethics Point system.

3/2020	Added sections 1- 3 adding procedural detail about referred and non-actionable reports.
2/2016	Changed “affected entities” to “scope” and “system compliance officer” to “chief compliance officer” to reflect new format.
4/2011	Added a new Section 4 to policy specifying how and when to communicate to callers.
1/2011	Changes per annual review, audit and OMIG evaluation tool: clarified that hotline is for “individuals” use, not just employees, and clarified respective roles of ArchCare System Compliance Officer and Entity Compliance Officer in investigating calls.
10/25/2006	New document

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Gifts, System-Wide

ORIGINATING DEPARTMENT: Compliance

Effective Date: 09/28/2021 (Original Effective Date: 9/6/2007)

MOST RECENT REVIEW/REVISION DATE: 4/23/2025

BOARD COMPLIANCE COMMITTEE APPROVAL DATE: 5/14/2025

Version: 9

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**PURPOSE:** To ensure that the ArchCare workforce remains within legal and ethical limits regarding receiving or giving gifts to/from residents, potential referral sources and other individuals or entities.

**ENTITIES AFFECTED** All ArchCare-sponsored entities.

**SCOPE:** This policy applies to the workforce<sup>12</sup> of ArchCare and its affiliated entities. Specifically, ArchCare “workforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term “workforce” also applies to contractors, subcontractors, agents and independent contractors who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare. In addition, this policy extends to the governing body and corporate officers.

**BACKGROUND:** The giving or receipt of gifts in the context of health care may implicate several statutes.<sup>13</sup> For example, the federal anti-kickback statute makes it a crime to solicit or receive any item of value (remuneration) made directly or indirectly,

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<sup>12</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

<sup>13</sup> There are several exceptions to these statutes, however, they are complex and beyond the scope of this policy. If you have any questions, please contact the Compliance Officer/Liaison for your program or the Chief Compliance Officer.

in cash or in kind, in return for referring an individual to a person for the furnishing (or arranging for the furnishing) of any item or service for which payment may be made in whole or in part under a federal health care program (*e.g.*, Medicare or Medicaid).<sup>14</sup> New York State has a similar prohibition that pertains to illegal remuneration in exchange for Medicaid referrals. Moreover, the federal civil monetary penalties law prohibits inducements to Medicare and Medicaid beneficiaries where the person offering the remuneration knows or should know that the remuneration is likely to influence the beneficiary to order or receive items or services from a particular provider.<sup>15</sup>

Consequently, the acceptance or giving of any gift or business courtesy from/to vendors or others with whom ArchCare presently or potentially conducts business involving federal health care program beneficiaries, goods or services may violate federal and state statutes and is strictly prohibited, unless otherwise authorized by this policy.

#### **POLICY:**

35. **Restrictions on gifts from those we serve or their families:** No member of the ArchCare workforce or ArchCare contractor may solicit, accept, or receive any gift, gratuity or remuneration in any form from a resident/patient or their family member, regardless of its value. The following are acceptable expressions of gratitude and do not constitute inappropriate gifts, gratuities or remuneration:
- a. Letters of thanks and appreciation, including those which mention staff by name, directed to their supervisor, department head, or the President and CEO, etc.;
  - b. Donations to ArchCare in honor of a member of the staff, or a department or unit of ArchCare; and
  - c. Token gifts directed to departments or units (but not to specific individuals), such as flowers or fresh fruit baskets.
36. **Restrictions on gifts to Medicare and Medicaid Beneficiaries:** Workforce members or ArchCare contractors may not give a Medicare or Medicaid beneficiary anything of monetary value that may influence the beneficiary to prefer an ArchCare provider over another provider. This includes the routine

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<sup>14</sup> Potential penalties for violating the federal anti-kickback statute include up to 10 years' imprisonment, or fines of up to \$100,000, or both.

<sup>15</sup> The current penalty for violating the civil monetary penalties law by giving remuneration to improperly induce a beneficiary to choose a particular provider of Medicare or Medicaid services is \$ 27,894 for each item or service for which payment may be made by Medicare or Medicaid. This amount is subject to annual adjustments.

waiving of copayments or deductibles<sup>16</sup> or providing goods or services for less than fair market value. Inexpensive gifts of nominal value are permitted, however. This means gifts of retail value of \$15 or less per item or \$75 combined per patient per year.

37. **Restrictions on gifts to/from vendors and other individuals and entities with business relationships with ArchCare:** No member of the ArchCare workforce or contractor may solicit, accept, offer or give any gift or gratuity of more than **nominal value** (defined below) to or from potential referrals sources, and/or other individuals and entities with which an ArchCare Entity has an actual or potential business relationship, except for fundraising undertaken in accordance with the ArchCare Entity's fundraising policies and procedures to ensure appropriate solicitation practices. For more information, see the ArchCare Fundraising Policy.
- a. No member of the ArchCare workforce or contractor may pay any commission, bonus, rebate or gratuity to any organization, agency, physician, employee or other person for referral of any resident/patient to ArchCare except for gifts of nominal amounts (see 3.c. of this Policy) made as recognition to employees facilitating transfers of individuals served by one ArchCare Entity to other ArchCare Entities while always preserving and honoring resident choice.
  - b. No member of the ArchCare workforce or contractor may accept any remuneration, rebate, gift, benefit or advantage of any form from any vendor or other supplier because of, or in exchange for, the purchase, rental or loan of equipment, supplies or services for ArchCare or the resident.
  - c. **Nominal Value:** Individual gifts valued above \$50 and gifts given by one individual or entity to an individual over the course of a year valued above \$100 in the aggregate are presumed to be of greater than nominal value. Also presumed to be of more than nominal value are gifts valued above \$200 in the aggregate given at one time by a single individual or entity to more than one person, e.g., to several employees for a single social event or meal.
38. **No gifts as a precondition of admission or services or to influence use of services:** No member of the ArchCare workforce or contractor may charge, solicit, accept or receive, in addition to any amount otherwise required to be paid by third-party payors (including Medicare and Medicaid), any gift, money, donation

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<sup>16</sup> Non-routine, unadvertised waivers of copayments or deductible amounts based on individualized determinations of financial need or exhaustion of reasonable collection efforts may be permitted.

or other consideration as a precondition of admission, expedited admission or continued stay in an ArchCare facility, except that arrangements for prepayment for basic services not exceeding three months are not precluded by this paragraph.

39. **No gifts to government employees:** No member of the ArchCare workforce or contractor may give any gift or gratuity to a government employee or official in connection with a business transaction or issue on behalf of ArchCare.
40. **Gifts or benefits to immediate family members of the workforce/ArchCare contractors are not permitted.** Gifts from vendors/referral sources/residents/patients to immediate family members of the ArchCare workforce or contractors are prohibited. For purposes of this Policy, “immediate family members” includes any of the following: your husband or wife; birth 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
41. While this Policy provides guidance for carious common circumstances, it is not exhaustive. Questions regarding a particular relationship, gift, or business courtesy should be directed to the SVP, Compliance.
42. Exceptions to this Policy must be disclosed to and approved by the SVP, Compliance, who shall retain information on the facts and circumstances of the case and include a summary of such facts and circumstances in the next scheduled meeting of the Compliance Committee of the governing body.

**RESPONSIBILITIES:** The senior official of each ArchCare facility, function, and program shall be responsible for ensuring that operational procedures conform to this policy and that staff are aware of this policy. All employees and contractors are responsible for carrying out this policy.

#### **REVISION HISTORY:**

Date	Change/Note
4/23/2025	Annual review and update of the policy.
5/1/2024	Annual review and update of the policies and changed the annual value of penalties.



5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes
01/10/2023	Annual review.
8/2021	Expanded definitions of the statutes that are implicated; Added restriction on gifts to immediate family members; reorganized the policy.
8/2016	Simplified policy in accordance with compliance program assessment recommendation and removed section on fundraising into separate corporate policy.
7/2014	Added provision prohibiting VP, Support Services from communicating with vendors regarding fundraising event.
5/2011	Incorporated section on business courtesies and solicitation for fundraising.

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Reporting Compliance Matters;  
Whistleblower/Non-retaliation/Non-Intimidation Policy for Good Faith Participation in  
the Compliance Program (System Wide)

ORIGINATING DEPARTMENT: Compliance

ORIGINAL EFFECTIVE DATE: July 16, 2012

Most Recent Revision/Review Date: 4/23/2025

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE:  
5/19/2025

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**ENTITIES AFFECTED:** All ArchCare-sponsored entities

**SCOPE:** This policy applies to the workforce<sup>17</sup> of ArchCare and its affiliated entities. Specifically, ArchCare “workforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term “workforce” also applies to contractors, subcontractors, agents and independent contractors<sup>18</sup> who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

In addition, this policy applies to all persons who report compliance issues, including Medicaid recipients of services.

**OVERSIGHT OF THIS POLICY:** The adoption and implementation of, and compliance with, this Policy shall be overseen by each affiliated entity’s designated Compliance Committee of the Board. The designated Compliance Committees may, in their discretion,

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<sup>17</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

<sup>18</sup> This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

authorize certain functions relating to the implementation of, and compliance with, this Policy to be performed by one or more employees, officers or trustees, but the designated Compliance Committees will, at all times, retain overall responsibility for all aspects of the oversight of this Policy. The Chief Compliance Officer has been designated by the Boards to administer this Policy and report to the Compliance Committees on issues related to this Policy.

**POLICY:** Care members must report unethical or illegal conduct or fraud, waste and abuse of which they become aware--and must cooperate in an investigation into such activity. ArchCare will not take disciplinary or retaliatory action against any care member for their "good faith participation in the Compliance and Ethics Program" (as defined below). Intimidation or retaliation in any form by any individual associated with ArchCare is strictly prohibited and is itself a serious violation of the Code of Conduct.

No affected individuals including but not limited to trustee, officer, key person,<sup>19</sup> employee or volunteer of ArchCare who in good faith reports any action or suspected action taken by or within ArchCare that is illegal, fraudulent, or in violation of any adopted policy of ArchCare shall suffer intimidation, harassment, discrimination or other retaliation, or in the case of employees, adverse employment consequences.

#### **DEFINITIONS:**

43. **Compliance matters**, include, but are not limited to:

- Failure to comply with applicable federal, state, and local laws, regulations, official guidance or federal health care program standards (*e.g.*, Medicare or Medicaid requirements);
- Failure to comply with ArchCare's Code of Conduct, policies or procedures; and
- Conflicts of interest, fraud and other ethical breaches by affected individuals or associates.

44. **"Good faith participation in the Compliance and Ethics Program"** includes, but is not limited to:

- reporting actual or potential issues or concerns, including but not limited to, any action or suspected action taken by or within ArchCare that is illegal, fraudulent or in violation of any adopted ArchCare policy;

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<sup>19</sup> These terms are defined in the Conflict of Interest Policy.

- cooperating with or participating in the investigation of such matters;
- assisting with or participating in self-evaluations, audits, and/or resolving compliance issues (remedial actions);
- reporting instances of intimidation or retaliation;
- reporting potential fraud, waste or abuse to appropriate State or Federal Entities; or reporting to appropriate regulatory officials as provided in New York Labor Law §§ 740 and 741.

**45. Good faith report:**

Any report of a compliance matter that is made without malice and that the person making the report has reasonable cause to believe is true.

**46. Report:**

Any complaint, allegation, report, or concern of a compliance matter made under this procedure.

**REPORTING PROCEDURE:**

**1. Raising Compliance Matters; Filing Reports.**

Affected individuals are encouraged to raise concerns regarding compliance matters with their immediate supervisor. If the concern is regarding their immediate supervisor, they are encouraged to report to their local Compliance Officer or Compliance Liaison, the Chief Compliance Officer, or Human Resources, as appropriate. Supervisors or other individuals receiving reports regarding compliance matters should contact their local Compliance Officer or Compliance Liaison, the Chief Compliance Officer, or Human Resources to determine next steps and should not investigate the matter themselves.

Affected individuals and others are always free to report compliance matters to their local Compliance Officer or Compliance Liaison, or the Chief Compliance Officer, regarding compliance matters. They may also report to Human Resources for issues regarding compliance with personnel policies.

Reports on compliance matters may be made:

- by phone, email, regular mail or in person to the local Compliance Officer or Compliance Liaison or the Chief Compliance Officer;

- to the Compliance Hotline (800) 443 0463 (which is toll free, operated by an outside vendor, and available 24 hours a day, 7 days a week. Calls to the Hotline may be made anonymously with the ability for the caller to receive reports and follow up questions. The number is posted prominently within ArchCare Entities and included in the compliance education provided to the ArchCare workforce and to ArchCare vendors).
- via a secure report online to [www.archcare.ethicspoint.com](http://www.archcare.ethicspoint.com)
- If the suspected misconduct being reported concerns the Chief Compliance Officer or the Entity Compliance Officer or Compliance Liaison, the employee may report through the ArchCare Compliance and Corporate Ethics Hotline (in which case the information will be forwarded directly to the ArchCare Board of Trustees' Compliance Committee) or the Boards of Managers of ArchCare Senior Life or ArchCare Advantage directly. See Compliance Program, Corrective Action and Response to Detected Offenses, System-Wide Policy.

#### **47. Anonymity/Confidentiality.**

**Compliance reports may be made anonymously, if a person chooses. If not made anonymously, the confidentiality of individuals reporting compliance issues will be maintained, except when the matter is subject to a formal disciplinary proceeding, or when it is under investigation by regulatory bodies like MFCU, OMIG, or law enforcement, or when legal proceedings require disclosure. Compliance files shall be located in a secure area to maintain appropriate confidentiality of reported information.**

### **PROCEDURES FOR INVESTIGATING RETALIATION/INTIMIDATION COMPLAINTS**

#### **1. Non-intimidation and Non-retaliation.**

ArchCare and its Affiliated Entities strictly prohibit intimidation, retaliation, discrimination, harassment or any other adverse action by management or any other person or group, either directly or indirectly, against any individual or group who reports a potential violation in good faith under the reporting system described in this policy or for other good faith participation in the Compliance and Ethics Program. Anyone believing that he or she or an employee or other person has been subjected to retaliation or intimidation for making a good faith report or for other good faith participation in the

Compliance and Ethics Program should report such matter to anyone designated to receive reports under this Policy.

#### **48. Reporting to Compliance Personnel**

Any complaint of retaliation or intimidation received by a supervisor is to be promptly reported to the Compliance Officer or Compliance Liaison of the relevant program or to ArchCare's Chief Compliance Officer. If an employee identifies her or himself when making the complaint, the individual receiving the complaint will advise that employee of the results of its investigation and any related corrective action taken as a result.

#### **49. Investigation and Corrective Action**

All allegations of intimidation or retaliation resulting from good faith participation in the Compliance and Ethics Program will be fully and completely investigated. The Chief Compliance Officer, or a designee, will oversee any investigations and take all necessary and appropriate actions in connection with any investigation. The Chief Compliance Officer, or a designee, will be assisted by internal staff and/or may solicit the support of external resources, as needed.

- All individuals who may have relevant information will be promptly interviewed. At the outset of the interview process, the interviewee will be reminded that retaliation and intimidation is a violation of ArchCare's Code of Conduct and this Policy, and that under certain circumstance, may be unlawful as well. The interviewee will also be reminded of ArchCare's disciplinary policy for failure to cooperate in a compliance-related investigation.
- All documentation related to the investigation will be kept confidential, consistent with the need to investigate the issue(s) raised. Investigative files will be kept secured in a central location under the control of the Chief Compliance Officer or designated staff. Such investigative files will be kept separate from personnel files and will be maintained for no fewer than ten years from the date of the conclusion of the investigation, or the imposition of disciplinary sanctions or corrective actions resulting therefrom, or for such longer period of time as may be required by applicable law.
- If the Chief Compliance Officer determines that an individual was improperly intimidated or retaliated against for good faith participation in the Compliance and Ethics Program, ArchCare will promptly take all appropriate corrective action as to the individual who was intimidated or

retaliated against. The Audit, Risk & Compliance Committee of the Board will retain oversight of all such corrective action.

- In addition, if the Chief Compliance Officer determines that an individual was intimidated or retaliated against for good faith participation in the Compliance and Ethics Program, appropriate disciplinary action will be taken against the offending person, in accordance with ArchCare's Compliance and Ethics Program.
- ArchCare may terminate contracts and affiliations based on retaliation or intimidation for good faith participation in the Compliance and Ethics Program, subject to the oversight of the applicable designated Compliance Committee of the Board.
- In order to prevent retaliation or intimidation against employees who in good faith participate in the Compliance and Ethics Program, all terminations of employment must be approved by ArchCare's Human Resources Department prior to being effectuated. The Human Resources Department must be advised of the employee's participation in the Compliance and Ethics Program prior to the termination decision or other adverse employment action being made.
- A person that is subject of a whistleblower complaint may not be present at or participate in Board or Board-level committee deliberations or vote on the matter relating to such complaint. The Board or designated Committee, in its discretion, may request that a person who is subject of a whistleblower complaint present information as background or answer questions at a Board or Committee meeting prior to the commencement of deliberations or related voting.
- Board members who are employees may not participate in any Board or Committee deliberations or voting relating to administration of the whistleblower policy,

#### **50. Disciplinary Action for Reports Made Not in Good Faith.**

ArchCare and its Affiliated Entities may take appropriate disciplinary or legal action in the event that a report of wrongdoing was fabricated or distorted to injure someone else or benefit the reporting individual, or was otherwise knowingly or recklessly inaccurate. Moreover, although ArchCare and its Affiliated Entities may consider "self-reporting"

favorably when determining appropriate disciplinary action, the individual remains subject to disciplinary actions for his or her improper acts.

## **DISTRIBUTION OF POLICY AND REPORTING REQUIREMENTS**

### **1. Policy Distribution.**

This Policy will be distributed to all directors, officers, key persons and employees of ArchCare, and to volunteers who provide substantial services to ArchCare. This may be done by posting on the ArchCare intranet. This policy is also available online at [archcare.org/compliance](http://archcare.org/compliance).

### **51. Reporting to the Governing Body**

The Chief Compliance Officer will advise the Audit, Risk & Compliance Committees as directed by the governing body, regarding any alleged acts of retaliation or intimidation in violation of this policy on an ongoing basis.

## **REVISION HISTORY:**

Date	Change/Note
4/23/2025	Annual review and update of the policy.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	Replaced “compliance program” with “compliance and ethics program”. Replaced board compliance committee with board audit, risk, and compliance committee.
8/2018	Revised title to reflect expanded “reporting” section and reference good faith participation in the compliance program. Revised to comply with the Not for Profit Corporation Law §715-b, Social Services Law §363-d, 18 N.Y.C.R.R. § 518.3 and OMIG Guidance. Added definition of “good faith participation in the compliance program.” Added “scope” and “oversight” sections. Added investigative procedures pertaining to retaliation/intimidation complaints.
4/2014	Revised to comply with the Nonprofit Revitalization Act.
1/2013	Clarified that intimidation of employees reporting unethical or illegal conduct is not tolerated either. Expanded reporting obligation to governing bodies and designated contractors as well as employees.



7/16/2012	Changes per annual review, amended to include Fraud, Waste and Abuse program.
1/2011	Changes per annual review.
9/6/2007	Original Policy

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

**SUBJECT:** Compliance and Ethics Program, Risk Assessment, Monitoring and Reviewing, System-Wide

**ORIGINATING DEPARTMENT:** Compliance

**EFFECTIVE DATE:** March 1, 2011

**MOST RECENT REVIEW/REVISION DATE:** 4/23/25

**BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE:** 5/19/2025

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**PURPOSE:** To establish requirement for ongoing risk assessment and monitoring program to detect Fraud, Waste and Abuse.

**SCOPE:** All ArchCare-sponsored Entities.

**POLICY:** ArchCare will conduct on-going risk assessments by having processes in place to continually monitor compliance with the Code of Conduct, Compliance and Ethics Program Policies and Procedures, and all applicable Federal and State laws, rules and regulations. To this end, the Chief Compliance Officer will ensure implementation of an effective system for routine monitoring and identification of compliance risks. The system includes internal monitoring and audits and, as appropriate, external audits, to evaluate ArchCare's compliance with federal health care program requirements (*e.g.*, Medicare and Medicaid) and the overall effectiveness of the Compliance and Ethics Program.

**PROCEDURE: NOTE: RISK ASSESSMENT IS ALSO ADDRESSED IN THE COMPLIANCE PROGRAM CHARTER. WHEN THERE IS A CONFLICT BETWEEN THIS DOCUMENT AND THE PROGRAM CHARTER, THE PROGRAM CHARTER SHALL PREVAIL.**

52. **Compliance Assurance Reviews.** The Chief Compliance Officer will ensure that specific compliance assurance reviews are conducted in accordance with the following procedures and protocols. The Chief Compliance Officer will work with

the Compliance Officers and Compliance Liaisons, in conjunction with the Compliance Committees, relevant Department Heads, and managers and supervisors, to arrange for the periodic review of various compliance matters, including, but not limited to, the following:

- a. Annual Self-Assessment of Risk. An internal risk assessment will be conducted to identify risk areas. These risk areas will be shared with the Chief Compliance Officer and Compliance Committee. Periodic reports on the improvement in the risk areas identified will be required. The Compliance Committee will be responsible for monitoring such improvement and compliance with applicable laws and regulations.
- b. Billing Reviews. Periodic reviews will be performed as to how services are ordered, performed, billed and paid, utilizing external consultants and/or counsel, as necessary and appropriate. Such reviews will include the selection of a sample of medical records and corresponding bills to assess compliance with ArchCare's medical record and billing policies and with applicable legal requirements.

Reviews may include probe "audits" of medical record documentation and bills, among other things. Significant variations from established benchmarks will trigger appropriate corrective action, including education and training and follow-up reviews.

- c. Review of Billing Denials and Patient Complaints. Periodic reviews will be performed of denials from Medicare, Medicaid and other third-party payers in order to determine whether any patterns of improper billing exist that need correction. In addition, billing complaints from patients will also be tracked to determine whether such complaints reflect the existence of possible patterns of improper billing or other compliance issues.
- d. Response to Third Party Audits. Following resolution of audits by third-party payers, the results of the audit will be reviewed by the Chief Compliance Officer or a designee, to determine if those results reflect, among other things, any patterns, systemic deficiencies or problems with compliance with State or Federal rules, regulations or laws, contractual requirements and/or payer policies.
- e. Quality of Care/Medical Necessity Reviews. The Chief Compliance Officer, or designee, will receive reports from the QA Committees which may include, but not be limited to the following quality-related issues: access to

care; meeting recognized standards of care; preventing and addressing deficiencies in care; honoring patient rights; ensuring staff are qualified to provide care; and ensuring that pharmaceuticals and medical devices ordered are done so free from any conflicts of interest.

Contract Reviews (contractor, subcontractor, agent or independent contract oversight). ArchCare will assess whether contractual arrangements were executed in compliance with and otherwise conform to the requirements of the Compliance and Ethics Program and applicable contracts will be update to address the requirement to comply with ArchCare Compliance Program (training and attestation);

- f. Mandatory Reporting. The Chief Compliance Officer will conduct reviews to ensure that all regulatory reporting obligations are met.
  - g. Credentialing. The SVP, Human Resources and Chief Medical Officer will ensure that all clinical personnel are appropriately credentialed (*i.e.*, properly licensed/certified and registered) and that all affected individuals or entities (*e.g.*, staff, vendors, referring providers) are not listed on any federal or state exclusion list.
  - h. Governance. The Chief Compliance Officer will regularly report to the Board of Trustees regarding the ongoing monitoring of ArchCare's compliance efforts. Follow-up reports with respect to identified areas of risk, or vulnerability, will be developed by the Chief Compliance Officer and shared with the Board and the Audit, Risk & Compliance Committee. Moreover, the Chief Compliance Officer will ensure that Trustees, Officers and Key Persons are educated regarding the Conflict-of-Interest Policy and that annual disclosure statements are completed and reviewed in accordance with the policy.
53. **Annual Work Plan.** The Chief Compliance Officer will produce an annual work plan to the Governing Body or delegee for its review that includes the specific compliance issues, audits and risk areas that will be addressed in the coming year. This may include, for instance, matters for which corrective action plans have been implemented that may require auditing or monitoring to confirm compliance. The Compliance Work Plan will address the following risk areas: billing and payments; medical necessity and quality of care issues; governance; mandatory

reporting requirements as related to the Medicaid Program; credentialing and other risk areas identified by the Chief Compliance Officer.

54. **Compliance and Ethics Program Reviews.** As part of ArchCare's compliance monitoring activities, the Chief Compliance Officer will work with the Compliance Officers and Compliance Liaisons to periodically assess whether:
- a. the anonymous reporting system is implemented and properly functioning;
  - b. reports and complaints have been tracked and adequately addressed;
  - c. identified actual or suspected violations of the law have been rectified and the wrongdoer (if any) disciplined; and
  - d. compliance issues identified in previous reviews have been appropriately addressed in training programs and alerts.

Moreover, on an annual basis, the Chief Compliance Officer or designee will review and evaluate the overall effectiveness of the operation of the Compliance and Ethics Program and whether any revision or corrective action is required. Based on such reviews, the Chief Compliance Officer or designee will then recommend to the Audit, Risk & Compliance Committee appropriate modifications of, or revisions to, the compliance policies, procedures, the Code of Conduct and the Compliance Charter.

In addition, on an ongoing basis there will be survey of care members regarding some of the elements of the compliance program. The result of the survey will be reported to the appropriate Compliance Committee and could result in appropriate modifications of, or revisions to, the compliance policies, procedures, the Code of Conduct and the Compliance Charter.

55. **Response to Findings.** Any findings of non-compliance identified in the course of any compliance assurance reviews described in this Policy or other compliance-related reviews that ArchCare may undertake, must be brought to the attention of a Compliance Officer, Compliance Liaison or the Chief Compliance Officer. If any of these Compliance personnel determine that there is reasonable cause to believe that a compliance issue may exist, an inquiry into the matter will be undertaken, with assistance from counsel as appropriate. In the event a violation of the Compliance and Ethics Program is discovered, appropriate remedial action will be taken in accordance with the Compliance, Corrective Action and Response to Detected Offenses, System-wide Policy.

56. **Tracking New Developments.** On a continuing basis, the Chief Compliance Officer or a designee, will ensure that all new regulatory, legal and other requirements issued by Federal or State government agencies and commercial payers with which ArchCare does business are reviewed by appropriate personnel. For example, such reviews may include, but are not limited to the following:

- a. Reviewing all new and revised rules and policies governing the coding and billing of services provided by ArchCare;
- b. Receiving and reviewing relevant Medicare bulletins, Local and National Coverage Determinations, Medicaid updates, annual updates to the Current Procedural Terminology (CPT), or other relevant guidance and policy changes;
- c. Communicating with the appropriate professional society as to recent initiatives or developments that might affect ArchCare, or new practices that might assist ArchCare in complying with rules and regulations that specifically apply to it; and
- d. Reviewing (a) relevant Special Fraud Alerts and relevant Advisory Opinions or other guidance issued by the U.S. Department of Health and Human Services, Office of the Inspector General (“OIG”); (b) compliance alerts, and other guidance issued by the New York State Office of the Medicaid Inspector General (“OMIG”); and (c) guidance and policies issued by other payers with which ArchCare does business.
- e. Reviewing all Work Plans issued by the OIG and OMIG.

Based on any relevant new developments, the Chief Compliance Officer, or a designee, will review existing policies and procedures to ensure that ArchCare is in compliance with the requirements of applicable Federal and State law and regulations as well as other contractual obligations. If necessary, appropriate corrective action will be taken.

#### REVISION HISTORY:

Date	Change/Note
4/23/2025	Annual review and revision of policy.

5/1/2024	Annual review and update of the policies and including information regarding ongoing survey of the compliance program.
5/1/2023	Review to align with the new OMIG Guidance. In addition, made formatting changes.
8/2022	Replaced board compliance committee with board audit risk and compliance committee, replaced compliance program with compliance and ethics program
8/2021	Revised title of the policy; revised policy for compliance with Social Services Law 363-d; added risk areas, expanded the types of reviews that should be undertaken, added new sections regarding annual work plan and tracking new developments.
1/2011	Changes per annual review
9/2007	Original Policy

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Record Retention & Document Destruction, System-Wide

ORIGINATING DEPARTMENT: Compliance

EFFECTIVE DATE: March 1, 2011

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE: 5/19/2025

MOST RECENT REVISION OR REVIEW DATE: 4/23/2025

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**PURPOSE:** The purpose of this Policy is to establish record retention guidelines that outline the requirements of record management, retention, security disposal and archiving. This Policy provides for the systematic review, retention and destruction of documents received or created by ArchCare and its Affiliated Entities (“ArchCare”) in connection with the transaction of its business. This Policy covers all records and documents, regardless of physical form, contains guidelines for how long certain documents should be kept and how records should be destroyed, and assigns responsibility for the enforcement of the policy within ArchCare.

**SCOPE:** This policy applies to all members of the ArchCare workforce including, but not limited to, employees, medical staff, volunteers, students, and contracted clinical and non-clinical staff performing work for or at ArchCare. “This policy applies to the workforce<sup>20</sup> of ArchCare and its affiliated entities. Specifically, ArchCare “workforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term “workforce” also applies to contractors, subcontractors, agents and independent contractors<sup>21</sup> who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing

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<sup>20</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

<sup>21</sup> This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".



of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

**POLICY:** It is the policy of ArchCare that all of its entities retain Records, as defined below, in accordance with applicable: (1) Federal, State and/or local law and regulation; (2) statutes of limitation; and/or (3) contractual requirements.

All Records must be retained in accordance with the Record Retention Guidelines and schedules developed by the applicable ArchCare Entity.

Each ArchCare Entity is responsible for ensuring the security, privacy and confidentiality of medical records, as required by law and Entity-specific policies.

#### **DEFINITIONS:**

**Non-Record.** Preliminary materials and other materials that are not records and that do not reflect the position or business of the ArchCare Entity, including Transitory Records, blank forms, preliminary working papers, superseded drafts and word processing files used to produce original records. Non-Records are not subject to the Retention Schedule and should be discarded when no longer of use.

**Record.** An ArchCare Entity Record shall be defined as any memorandum, writing, entry, print, representation or combination thereof of any act, transaction, occurrence, or event made or received in the regular course of business. Generally, a Record contains information with operational, legal, fiscal or historic value. A Record is defined broadly as information and includes documents, books, statements, and analyses, whether on paper or contained on microfiche, microfilm, optical disk, laser disk, or other magnetic media. Records also include data in electronic format intended for use by a computer.

**Record Retention Period.** The time during which records must be maintained by a corporate entity because they are needed for operational, legal, fiscal, historical, or other purposes.

**Transitory Record.** A Transitory Record is a record that is intended to be an informal communication of information and it is short lived. Examples of Transitory Records include voicemail messages, instant messages, telephone messages, post-it notes and e-mail messages when such messages are informal in nature and have short-lived or no administrative value.

**RESPONSIBILITIES:** Each ArchCare Entity, including ArchCare, must appoint a Records Coordinator who shall be responsible for the oversight of this Policy. All

questions regarding the scope or meaning of the policy, as well as specific questions regarding the retention of a record should be addressed to the Records Coordinator.

Unless otherwise indicated, Department Heads within each ArchCare Entity are responsible for creating, and no less than annually, reviewing and revising, and complying with the record retention schedule of their department, including overseeing the off-site storage of records, if necessary, and the destruction of records in accordance with the record retention schedule.

The Records Coordinator shall be responsible for maintaining the Entity's record retention schedules.

At least annually, the Records Coordinator shall coordinate the destruction of all records stored at off-site storage facilities and records maintained onsite in accordance with the Entity's record retention schedules.

All employees have an affirmative obligation to inform the Records Coordinator of any audits, investigations or litigation that they are aware of with regard to the ArchCare Entity or which are anticipated.

#### **PROCEDURES:**

- a. **Record Management and Retention.** Each ArchCare Entity shall retain records for the period of their immediate or current use, unless longer retention is necessary for historical reference or to comply with contractual, legal, or regulatory requirements. Each ArchCare Entity shall establish and maintain record retention schedules, containing a list of records and prescribing the periods of authorized retention. Record retention guidelines for basic: (1) Business and Administrative Records; (2) Finance/Purchasing/Reimbursement Records; (3) Employment/Safety Records; and (4) Facility/Clinical Records (collectively "Basic Record Retention Guidelines") are attached to this Policy as a guide. Each ArchCare Entity shall retain records consistent with these guidelines and shall assure that their record retention schedules incorporate all the types of records required to be maintained by law or regulation. For types of records not addressed in the Basic Record Retention Guidelines, each ArchCare Entity shall retain the records for no less than the length of time required by federal or state law or regulation or to prove compliance with a law or regulation, and shall maintain a corresponding retention schedule.
- b. **Electronic Documents and Records.** Electronic documents will be retained as if they were paper documents. Any electronic records that fall into one

of the document types on the record retention schedule will be maintained for the appropriate amount of time. Non-record email not meeting the definition of record includes transitory email inboxes which are primarily generated for informal communication of information. All employees are responsible for retaining those emails sent or received that constitute records in an appropriate file system in accordance with this record retention policy. Email inboxes and sent mailboxes do not constitute *de facto* filing system for emails that constitute records and are subject to a **180-day deletion policy**. Email folders may be created, however, to organize and classify email by message content and retention period that parallels an existing paper-based file plan.

- c. **Off-Site Storage; Labeling and Marking.** Records that are stored off-site shall be labeled and marked with a disposal date equal to or beyond the period established for retention. Record storage containers and systems must be labeled in sufficient detail that permits prompt and accurate identification should retrieval of the medical records become necessary. The disposal date should always be December 31 of the last year for which the file must be retained. For example, a document dated May 23, 2014 with a ten-year retention period would be designated for destruction on December 31, 2024.
- d. **Record Destruction/Annual Review.** Each ArchCare Entity will conduct a file review and purge process on at least an annual basis. This process consists of identifying and destroying unnecessary duplicate and multiple copies of documents, including drafts; reviewing and destroying documents which have exceeded their required retention period; and identifying, grouping and labeling documents which require retention and transferring these documents to the designated records storage site. Documents will be destroyed only in accordance with the Records Retention Schedule. Only Department Heads are permitted to authorize the destruction of Records. If there is any question as to how long a particular document should be retained, that document should not be destroyed until the question has been resolved.

Confidential records, including records containing Protected Health Information, financial and personnel-related documents, and other records subject to confidentiality restrictions will be destroyed in a manner that ensures confidentiality, such as shredding, mutilation or incineration in

accordance with the policy and procedure established by each ArchCare Entity.

- e. **Record Destruction Suspension for Audit, Investigation or Litigation.** Document destruction will be suspended immediately if the ArchCare Entity knows such documents are (i) relevant to litigation, criminal and/or civil investigations, audits, or needed for ongoing administrative proceedings, (ii) reasonably calculated to lead to the discovery of relevant records in a legal proceeding, (iii) reasonably likely to be requested during discovery in a legal proceeding, or (iv) subject to a pending discovery request in a legal proceeding. This includes, but is not limited to instances involving: (a) receipt of notice regarding the initiation of an audit or investigation by an outside agency (e.g., a Medicare or Medicaid audit); (b) receipt of service of legal process which involves an ArchCare Entity's records; or (c) receipt of a complaint that the ArchCare Entity determines may lead to a formal action or investigation.

The Records Coordinator will maintain a list of all such claims, investigations, audits, and litigations that will be reviewed by the Department Head or his/her designee prior to commencing any record destruction process in accordance with this Policy. Such list will be herein referred to as a "watch list."

Department Heads will evaluate the documents under consideration for destruction to determine if the documents (1) exceed the retention period on the Records Retention Schedule and (2) exceed contractual time frames applicable and are not on the "watch list."

Once the litigation, criminal and/or civil investigations and/or audits or proceeding are finalized, the relevant records may be destroyed in accordance with the applicable retention schedule and the requirements of this Policy.

- f. **Lost, Damaged or Destroyed Record**

Medicaid Entities/Providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request.

If ArchCare becomes aware that records have been damaged, lost or destroyed they are required to report that information to the OMIG Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery.

If ArchCare entity discovers a lost, damaged or destroyed record, it must contact the Chief Compliance Officer to prepare the appropriate self-disclosure documentation to NYS Office of Medicaid Inspection General.

- g. **Disciplinary Action.** Violations of this Policy will result in disciplinary action up to and including termination.
- h. **Interpretation.** Any questions regarding the application of this Policy or retention requirements for specific types of records should be referred to the ArchCare Entity Compliance Officer of Compliance Liaison or to the Chief Compliance Officer.

#### REVISION HISTORY:

Date	Change
4/23/2025	Annual review.
5/1/2024	Annual review and update of the policies incorporating requirements for self-disclosure of a lost, damaged or destroyed record.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes and added record retention for compliance program.
8/2022	Replaced “Board Compliance” with “Board Audit, Risk, and Compliance” and replace “compliance program” with “compliance and ethics program”
9/2021	Deleted reference to Sarbanes-Oxley which makes it a crime to alter, falsify, destroy, etc. any documents with the intent to impede, obstruct, influence a federal investigation; Reorganized Policy/Procedures Sections. Revised Record Destruction section and Definition of Record. Added reference to “Compliance Liaison” in Responsibilities section. Expanded Procedures Section.

	Added "Interpretations" section and recommendations for longer retention periods for certain Records.
11/2019	Corrected mistake in Section B. changed email inbox and sent mail box deletion period to 180 days.
4/2014	Changed reference to email inbox and sent mail box deletion period from 90 to 180 days.
9/2012	clarified employee responsibilities to maintain record system apart from email inbox. See Section B.
12/30/2008	Board Approved Policy
11/2011	Changes per annual review

**SCHEDULE A: BUSINESS AND ADMINISTRATIVE RECORDS  
RETENTION GUIDELINES**

DOCUMENT	RETENTION PERIOD
Articles of Incorporation	Permanent
Board Meeting and Committee Minutes	Permanent
Board Policies/Resolutions	Permanent
By-laws	Permanent
Construction Documents	Permanent
Fixed Asset Records	Permanent
IRS Application for Tax-Exempt Status	Permanent
IRS Determination Letter/Group Ruling	Permanent
Contracts (after expiration)	7 years
Correspondence (general)	3 years
Administrative Policies and Procedures	10 years
Corporate Compliance Documents	10 years
Donor Records and Acknowledgement Letters	7 years
Grant Applications and Contracts	5 years after completion
Insurance Policies	Permanent
Real Estate Documents	Permanent

**SCHEDULE B: FINANCE/PURCHASING/REIMBURSEMENT RECORDS RETENTION  
GUIDELINES**

DOCUMENT	RETENTION PERIOD
External Audit Reports	Current year + 15 years
Budget Work papers	Current year + 15 years
Financial Statements	Current year + 15 years
Collection Records	Current year + 15 years after audit
Purchase Orders/Supply Requisitions	Current year + 15 years
Financial Reports and Workpapers	Current year + 15 years
Cost Reports and Workpapers	Current year + 15 years except records relating to Base Year which should be maintained for as long as base year is used plus 2 years.



## SCHEDULE C: EMPLOYMENT/SAFETY RECORDS RETENTION GUIDELINES

DOCUMENT	RETENTION PERIOD
Employment Testing, including any exams considered in connection with personnel action.	6 years from date of test.
Employment Contracts	Active + 6 years.
Personnel files including employee biographical data; employment contracts; records of additions to and deletions from pay; compensation rate changes; all records related to FMLA leave (excluding employee health records); all records related to Reasonable Accommodations; employment terminations, layoffs, promotions, demotions and transfers; tuition reimbursement records; W-4's; IT-2104's; training certificates.	7 years post termination
INS Form I-9 (retained separate from personnel file)	7 years post termination
Payroll and Compensation (Basic and Supplemental, such as wage rate tables, time sheets, earnings cards, docs indicating daily start/end times)	6 years
Earnings Records	6 years
Records of All Volunteers, Students, or Other Non-Compensated Personnel	6 years
EEO Recording/Reporting:  100 or more employees – EEO-1 Apprenticeships – EEO-2 Chronological apps Others for EEO-2	6 years
Employment Benefits/ Pensions/ Reporting Contributions  Benefit Plans generally  Plans or trusts that provide income including in “regular rate” of pay for FLSA  ERISA filings and related records	Active + 6 years

DOCUMENT	RETENTION PERIOD
Worker's Compensation Records	18 years – for occupational injuries
Educational Assistance Financing	Current year + 6 years
Paid Time Off Records	Current year + 6 years
W-2 Forms	Tax return filing date + 15 years
W-9 Letters	Tax return filing date + 15 years
W-4 Forms	Tax return filing date + 15 years
Form 990	Tax return filing date + 15 years
Form 940 & 941	Tax return filing date + 15 years.
Form 1099	Tax return filing date + 15 years.
Employee Training Certification	Active + 6 years
Training Program Materials	Active + 6 years
Certificates of Completion of Infection Control & Barrier Precaution Training Courses	21 years
Nursing Records Training	Active + 6 years
FMLA Leave Records	6 years
Reasonable Accommodation	6 years

DOCUMENT	RETENTION PERIOD
Employee Medical Records	Active + 3 years (except to health insurance claims records maintained separately from the employer's medical program and its records; first aid records; medical records of employees who work for less than 1 year.)
OSHA Log (OSHA Form 300)	Active + 30 years
OSHA Form 300A (Summary of Work-Related Injuries and Illnesses)	Active + 30 years
Health & Safety Illness/ Injury/ Accident Reports (OSHA Form 301)	Active + 30 years
Health & Safety Hazardous Employee Exposure	Active + 30 years
Health & Safety Noise Exposure Measurements	Active + 30 years
Health & Safety Audiometric Test Record	Active + 30 years
Health & Safety Emergency Action Plans (not specifically mentioned in regulations)	Active + 30 years
Material Safety Data Sheets	Active + 30 years
Fire Protection	6 years

## SCHEDULE D: FACILITY AND CLINICAL RECORDS RETENTION GUIDELINES

DOCUMENT	RETENTION PERIOD
Patient Medical Records – Adult	Recommendation: 6 years from date of discharge
Patient Medical Records – Minor	Recommendation: 6 years from date of discharge or 2 years from age of majority, whichever is longer; or at least 6 years after the patient's death
Accident reports and related records	6 years
Census Record of Residents	10 years
Periodic reports, summaries, logs required by administrative policy	6 years
Disaster preparedness records	Permanent
Facility committee records	6 years
Fire Safety Records	6 years
HIPAA Mandated Records	6 years
Infection control and monitoring records	10 years
Internal investigations or non-fiscal audit records	Recommendation: 10 years
Quality assurance records	Recommendation: 10 years
Compliance Documents (documents supporting the adoption, implementation and operation of an effective Compliance Program)	6 years Recommended: 10 years

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Report and Return of Overpayments, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

ORIGINAL APPROVAL DATE: 10/14/2021

AUDIT, RISK & COMPLIANCE COMMITTEE APPROVAL DATE: 5/14/2025

MOST RECENT REVIEW/REVISION DATE: 4/23/2025

Version: 4

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**PURPOSE:** The purpose of this policy is to establish the process for timely reporting and return of identified overpayments as required under Section 6402 of the Patient Protection and Affordable Care Act, federal regulations at 42 C.F.R. §401.305, New York Social Services Law §363-d and the Office of Medicaid Inspector General's ("OMIG") Self-Disclosure Program.

**ENTITIES AFFECTED:** All ArchCare-sponsored entities

**POLICY:** It is ArchCare's policy not to retain any payments to which it is not entitled; to exercise reasonable diligence in timely investigating and quantifying any and all potential overpayments; and to promptly report, return and explain in writing to the appropriate government agency, contractor or payer (including but not limited to, the appropriate Medicare contractor, the New York State Department of Health or OMIG), any identified overpayments in accordance with applicable legal, regulatory, contractual and/or other requirements or guidance.

Any **overpayments** discovered during routine monitoring, internal audits or investigations and confirmed as identified overpayments shall be reported, returned and explained as per this policy.

### DEFINITIONS:

**Overpayment** is defined as any funds that a person receives or retains under title XVIII (Medicare) or title XIX (Medicaid) to which the person, after applicable reconciliation, is not entitled. An overpayment includes funds that a Medicare Advantage (MA)

organization has received based on data submitted to CMS for payment purposes that after reconciliation, the MA organization is not entitled.

Overpayments include, but are not limited to, reimbursement received due to: upcoding, incorrect coding resulting in a higher level of reimbursement, insufficient or lack of documentation to support billed services, services billed under the wrong provider, lack of medical necessity, duplicate payments, payments to the incorrect payee, or any other finding that reflects an overpayment was received by an ArchCare Entity as a result of inaccurate or improper coding or reporting of health care items or services.

**Identified an overpayment** means the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. That is, the person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that an over payment was received and quantified if the person fails to exercise reasonable diligence and the person in fact received an overpayment.

**Lookback period.** An overpayment must be reported and returned if a person identifies the overpayment within 6 years of the date the overpayment was received.

**Reasonable diligence** includes both proactive compliance activities conducted in good faith to monitor the receipt of overpayments, as well as investigations conducted in good faith and in a “timely manner” in response to obtaining credible information about a potential overpayment. Medicare considers a “timely manner” to be at most six (6) months from receipt of credible information, except in extraordinary circumstances.

## **PROCEDURE:**

- 1. All reports or other information indicating that an overpayment may have been received during the lookback period must be immediately brought to the attention of the entity’s Compliance Officer or Compliance Liaison or to the Chief Compliance Officer.**

The Compliance Officer, Compliance Liaison or the Chief Compliance Officer must ensure that the entity exercises reasonable diligence to quantify any potential overpayments.

- 2. Deadline for Reporting and Returning Identified Overpayments**

- a. Medicare Part A and Part B.** For identified overpayments received from Medicare Part A and/or Medicare Part B, the deadline for reporting and returning the overpayment is the later of either:

- 60 days from the date the overpayment is identified or
  - the date any corresponding cost report is due, if applicable.
- b. Medicare Advantage (Part C). For identified overpayments received from Medicare Part C, the deadline for reporting and returning the overpayment is no later than 60 days after the date the overpayment is identified, unless otherwise directed by CMS for purposes of risk adjustment data validation audit.<sup>22</sup>
- c. Medicaid. The same deadline as defined above in 2.a is applicable to identified Medicaid overpayments. In addition, please refer to NYS OMIG Guidance of Self-Disclosure.

OMIG's Self-Disclosure Program includes two pathways for Medicaid Entities/Providers to report, return and explain self-identified overpayments. Both the Full Self-Disclosure Process and the Abbreviated Self-Disclosure Process begin with the same steps. A Medicaid Entity/Provider discovers that they are in receipt of a Medicaid overpayment and investigates to identify and explain it.

Chief Compliance Officer must be consulted to investigate and prepare the OMIG Self-Disclosure.

- d. Other Third-party Payers. In the case of overpayments by commercial/other third-party payers, overpayments shall be reported and returned in accordance with any contractual obligation or if there is no specified deadline, the overpayment must be returned with 60 days from the date the overpayment is identified by the payer or the ArchCare Entity.
- e. PACE  
PACE as a Medicaid Managed Care Organization is required to establish Self-Disclosure Programs including policies and procedures for participating Providers and other subcontractors to report, return and explain Managed Care overpayments within sixty (60) days of identification. Network Providers should self-disclose identified Managed Care overpayments to PACE in accordance with ArchCare's Self-Disclosure Policy and Procedure.

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<sup>22</sup> In 2018, the regulation governing Medicare Part C overpayments was found to be invalid by a Federal District Court. That ruling was overturned by the U.S. Court of Appeals for the District of Columbia Circuit on August 13, 2021 (See United Healthcare Insurance Company v. Becerra, 2021 WL 3573766).

### **3. Responsible Party for Processing Return of Identified Overpayments**

The CFO, in consultation with the Chief Compliance Officer, shall be responsible for submitting the return of identified overpayments and any applicable report. For Part C overpayments, the CFO must certify (based on best knowledge, information, and belief) that the information provided for purposes of reporting and returning of overpayments is accurate, complete, and truthful.

### **4. Process to Report and Return Identified Overpayments**

- a. Medicare Part A and Part B. With the limited exception described below, Medicare overpayments shall be returned to the Medicare Contractor that paid the claim, at the address provided by the Medicare Contractor using an applicable claims adjustment, credit balance, self-reported refund, or other reporting process as set forth by the Medicare Contractor.
- b. Medicare Part C. The MA organization must notify CMS of the amount and reason for the overpayment, using a notification process determined by CMS and return identified overpayments in a manner specified by CMS.
- c. Exception for Fraud. Identified Medicare overpayments that resulted from fraud shall be disclosed using the OIG's Self-Disclosure Protocol or the CMS Voluntary Self-Referral Disclosure Protocol, as applicable.
- d. Medicaid. Medicaid overpayments shall be reported and returned to the NYS Department of Health; a written explanation of the reason for the overpayment shall be provided to the OMIG through its Self-Disclosure Program. Information regarding OMIG's Self-Disclosure Program is available here: <https://omig.ny.gov/provider-resources/self-disclosure>. A Self-Disclosure submission related to a Medicaid program overpayment requires completion of a [Self-Disclosure Statement, Certification](#), and a [Claims Data File](#) of affected Medicaid claims, or [Mixed Payer Calculation \(MPC\) form](#) for Excluded provider disclosures. If the Medicaid program overpayment is not related to claim data or an excluded or non-enrolled provider, additional explanation to allow for the verification of the overpayment is required. Please refer to OMIG Self disclosure guidance.



**REVISION HISTORY:**

Date	Change/Note
4/23/2025	Annual review and update of policy.
5/1/2024	Annual review and update of the policies. Additional information related to self-disclosure was added.
5/1/2023	Review and update to align with the new OMIG Guidance on self-disclosure. In addition, made formatting changes.
07/25/2016	New policy

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

**SUBJECT:** Compliance and Ethics Program, Corrective Action and Response to Detected Offenses, System-Wide

**ORIGINATING DEPARTMENT:** Compliance

**ORIGINAL CREATION DATE:** 9/2007

**BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE:** 5/14/2025

**MOST RECENT REVIEW/REVISION DATE:** 4/23/25

**Version:** 9

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**PURPOSE:** To ensure that detected compliance matters are corrected promptly and thoroughly to reduce the potential for recurrence and ensure ongoing compliance with federal health care programs requirements (*e.g.*, Medicare and Medicaid).

**SCOPE:**

This policy applies to the workforce<sup>23</sup> of ArchCare and its affiliated entities. Specifically, ArchCare “[w]orkforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term “workforce” also applies to contractors, subcontractors, agents or independent contractors<sup>24</sup> who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

**POLICY:** Whenever a compliance matter is uncovered, regardless of the source, ArchCare and its Affiliated Entities will ensure that prompt, thorough, appropriate and effective corrective action is implemented. In discharging this responsibility, the entity

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<sup>23</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

<sup>24</sup> This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

Compliance Officer or Compliance Liaison and/or the Chief Compliance Officer may work in consultation with outside counsel and others, as appropriate to correct the problem. All care members are expected to assist in the resolution of compliance issues. Failure to cooperate could lead to discipline up to and including termination.

Any corrective action and response implemented must be designed to ensure that the violation or problem does not recur (or to reduce the likelihood that it will recur) and must be based on an analysis of the root cause of the issue. In addition, the corrective action plan should include, whenever applicable, a review of the effectiveness of the corrective action following its implementation. If such a review establishes that the corrective action plan has not been effective, then additional or new corrective actions must be implemented.

**ENTITIES AFFECTED:** All ArchCare-sponsored entities

**PROCEDURE:**

57. Upon conclusion of an investigation involving a compliance matter, and upon receipt of the Report of Findings, the President and CEO shall decide upon an appropriate corrective action after consultation with the Chief Compliance Officer, and, as applicable, the entity Compliance Officer or Compliance Liaison, legal counsel, the VP, Human Resources, and other staff as appropriate and necessary.
58. Corrective actions may include, but are not limited to:
  - a. Informing and discussing with the offending care member both the violation and how it may be avoided in the future;
  - b. Providing remedial education (formal or informal) to ensure that there is an understanding of the applicable laws, rules, regulations and/or requirements;
  - c. Conducting a follow-up review to ensure that the problem is not recurring;
  - d. Having care members go through a cycle or cycles of remedial education and/or focused audits;
  - e. Suspending billing, in whole or in part, of the services provided by a specific physician/practitioner;
  - f. Refunding any past payments that resulted from any improper bills, to the extent required or otherwise appropriate (see the [Compliance and Ethics Program, Report and Return of Overpayments, System-Wide Policy](#));

- g. Promptly self-disclosing to an appropriate governmental agency or other payer, to the extent required or otherwise appropriate (including, but not limited to the federal DHHS' Office of Inspector General (OIG), the Centers for Medicare and Medicaid Services (CMS) or the New York State Department of Health, Office of the Medicaid Inspector General (OMIG) (consistent with ArchCare's self-disclosure policy);
  - h. Modifying or improving ArchCare's business practices; and/or
  - i. Modifying or improving the Compliance and Ethics Program to better ensure continuing compliance with applicable federal and state laws, rule, regulations, federal health care program requirement and/or other contractual requirements.
59. If a Compliance Officer, Compliance Liaison or the Chief Compliance Officer discovers credible evidence that criminal conduct may have occurred, ArchCare shall promptly investigate the matter to determine if specific corrective action and/or notification of appropriate governmental authorities is warranted under the circumstances. All instances in which credible evidence of a potential violation of any law (whether criminal, civil or administrative) is discovered will be promptly referred to legal counsel to evaluate the seriousness of the allegations and the necessity and timing of any disclosure to appropriate New York and/or federal authorities.
60. If the President & CEO and the Chief Compliance Officer cannot reach agreement on the appropriate response to an issue, the issue shall be reported to the relevant governing body, whether the Audit, Risk & Compliance Committee of the Board of Trustees, the Management Committee of the Catholic Special Needs Plan, LLC., or the Board of Managers, Catholic Managed Long Term Care, Inc., for resolution.
61. In consultation with the President & CEO, the Chief Compliance Officer may decide to refer potential fraud waste and abuse issues to the NBI MEDIC<sup>25</sup> and serious issues of program noncompliance to CMS, OIG or New York State DOH or OMIG. If the President & CEO and the Chief Compliance Officer cannot reach agreement on whether or not to refer the issue to regulatory or enforcement

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<sup>25</sup> NBI MEDIC is the acronym for the National Benefit Integrity Medicare Drug Integrity Contractor. The purpose of the NBI MEDIC is to detect and prevent FWA in the Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs.

agencies, the issues shall be escalated to the Audit, Risk& Compliance Committee of the Board of Catholic Health Care System for resolution.

## REVISION HISTORY:

Date	Change/Note
4/23/25	Annual review and update of the policy
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance. In addition, made formatting changes.
8/2022	Annual review.
8/2021	Removed sections on investigations to the Compliance, Investigating Compliance Matters, System-wide policy. Added Purpose and Scope; expanded title of the policy, Policy section and possible corrective actions.
11/2018	Added #14 allowing Compliance Officer to refer serious compliance or potential fraud, waste, and abuse issues to NBI MEDIC, CMS, DOH or OMIG. Added to #13: while no time limit on investigations in general, each one should be concluded within reasonable timeframe given their facts and circumstances. Compliance Committees and Board should review investigations periodically and determine whether they should be referred to law enforcement or third party for conclusion.
2/2018	Added #13 requiring investigations to be concluded within reasonable time period after offense is detected.
6/2014	Added standardized Corrective Action Plan form to summarize findings and corrective action plan. Form will be approved by Administrator or Head of Program and appropriate Compliance Officer.
5/2012	Changes per annual review: add more detailed response and findings process. Changed title from “Internal Investigations of Compliance Issues”
1/2011	Changes per annual review
9/2007	Original Policy

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Sanction Screening, System-Wide

ORIGINATING DEPARTMENT: Compliance

EFFECTIVE DATE: July 1, 2011

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE:  
5/14/2025

Version: 9

MOST RECENT REVIEW/REVISION DATE: 4/23/2025

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**PURPOSE:** To comply with health care providers' obligation to screen employees, prospective employees, contractors, and referral sources to determine if they have been excluded or terminated from participation in federal and/or state health care programs.

**ENTITIES AFFECTED:** All ArchCare-sponsored Entities.

**SCOPE:** This policy applies to the workforce<sup>26</sup> of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors<sup>27</sup> who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

### DEFINITIONS:

**Ineligible individual/entity:** Anyone who: 1) is currently excluded, debarred, or otherwise ineligible to participate in the federal and/or state healthcare programs,

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<sup>26</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

<sup>27</sup> This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

or in federal procurement or non-procurement programs; 2) has been convicted of a criminal offense related to the provision of healthcare items or services but has not yet been excluded, debarred, or otherwise declared ineligible.

**Clinician:** A professional who provides care and/or treatment to an ArchCare patient, member, or participant, such as, but not limited to, a physician, a dentist, a nurse, or a therapist.

**Exclusion Lists:** The “Exclusion Lists” include the following three internet sources that must be checked in accordance with the requirements of this Policy and Procedure:

- <https://exclusions.oig.hhs.gov/> (the United States Department of Health and Human Services, Office of Inspector General’s [“OIG”] List of Excluded Individuals/Entities);
- <https://sam.gov/content/home> (the General Service Administration’s System for Award Management); and
- <https://omig.ny.gov/medicaid-fraud/medicaid-exclusions> (the New York State Medicaid Exclusions List, available on the New York State Office of the Medicaid Inspector General’s [“OMIG”] website).

Other sources and lists may also be checked as ArchCare deems necessary and appropriate, including all other state jurisdictions for Medicaid exclusions. For example, if a potential staff member’s resume or application indicates that he or she worked in a state(s) other than New York, the equivalent state-specific lists, if available, should also be checked. If the person is excluded in that state, that individuals might be precluded from being employed at all ArchCare programs.

**Federal Health Care Program:** A “Federal health care program” is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program. For example, some of the better known Federal health care programs include, but are not limited to, Medicare, Medicaid, TRICARE and veterans’ programs.

**POLICY:** ArchCare is committed to using good faith, reasonable efforts to not knowingly employ, contract with, or otherwise do business with, individuals or entities that are excluded, debarred or suspended from, or otherwise ineligible to participate in, Federal and state health care programs or in Federal or state procurement or non-procurement

programs. ArchCare shall conduct monthly screenings to ensure that it will not employ, retain, pay, grant staff privileges to, or otherwise affiliate with individuals or entities that are excluded from participation in a Federal or state health care program.

## **PROCEDURE:**

### **A. RESPONSIBILITIES:**

The **Vice President, Human Resources**, ArchCare, shall be responsible for ensuring that **employees** of ArchCare and Affiliated Entities are screened in accordance with this policy.

The **Executive Directors** of ArchCare Entities are responsible for ensuring that **non-employed clinicians** are screened in accordance with this policy.

The **Vice President, Support Services, and the Chief Compliance Officer** (for those contracts that are put through the contract review process) are responsible for ensuring that **individuals or entities entering into a business relationship with ArchCare** are screened in accordance with this policy.

The **Chief Compliance Officer** is responsible for ensuring that **members appointed to any of the governing bodies** of ArchCare Entities are screened prior to appointment in accordance with this policy.

Any ArchCare executive entering into a business relationship on behalf of an ArchCare Entity is responsible for ensuring that such individual or entity is screened in accordance with this policy.

ArchCare Executive Directors are responsible for ensuring that referral sources are screened in accordance with this policy.



## B. SCREENING OF POTENTIAL AND CURRENT EMPLOYEES

**Pre-employment Screening.** Prior to employment, ArchCare Human Resources staff shall verify that any prospective employee of ArchCare and its Affiliated Entities has not been prohibited from participation in federal and/or state health care programs by doing a manual check of the Exclusion Lists on KChecks.

**Monthly Screening of Employees.** Human Resources staff shall monthly upload new employees to the KChecks database so that checks are conducted monthly thereafter.

**Upload and Monthly Screening of Employees who transfer from one ArchCare payroll to another:** At any time an employee is moved from one ArchCare payroll company to another, Human Resources staff (Corporate HR Operations Coordinator) shall upload that employee to the KChecks database so that checks are conducted monthly thereafter.

## C. SCREENING OF POTENTIAL AND CURRENT CLINICAL PROVIDERS

**Screening prior to credentialing.** Prior to a non-employed clinician furnishing services at or for ArchCare, an ArchCare Nursing Home, or an ArchCare Program, the Executive Directors or his/her designee must verify that s/he has not been prohibited from participation in federal and/or state health care programs by doing a manual check of the Exclusion Lists on KChecks. The Executive Directors or his/her designee must upload the name on KChecks and resolve matches if necessary.

**Monthly Screening.** KChecks will perform screening checks of the Exclusion Lists monthly thereafter.

**Scope of Screening.** This screening shall include, but not be limited to, nurses referred from staffing agencies, non-employed therapists, and non-employed physicians.

### **Identifying Numbers.**

Agency Nurses' license number will be used as the database identifier, preceded by the letter "N."

Non-employee therapists' license number will be used as the database identifier, preceded by the letter "R" (standing for "rehab").

Non-employee medical staff's license number will be used as the database identifier, preceded by the letter "M."

#### **Contract Addendum Alternative.**

If it is impractical for all programs to perform the screening prior to an individual providing services via a staffing entity (or some other entity) to the program (e.g., agency nurses arriving on site immediately prior to a shift) program shall amend contract with the staffing entity to require the staffing entity to perform monthly sanction screenings (see [Compliance and Ethics Program, Sanction Screening, Staffing Agency Contract Addendum, System-Wide.](#)) Once the agency staff are onboarded they will be entered in to the Kchecks system to be monitored by program staff.

### **D. SCREENING OF POTENTIAL AND CURRENT VOLUNTEERS, STUDENTS, CONSULTANTS**

The Compliance Officer or Compliance Liaison (or a designee) of the relevant ArchCare Entity shall be responsible for loading and checking the Exclusion Lists for the names of consultants.

### **E. SCREENING OF POTENTIAL AND CURRENT VENDORS AND CONTRACTORS**

#### **Centrally-reviewed Business Arrangements**

For business relationships subject to the contract review process, the Chief Compliance Officer or designee shall verify that any prospective vendor, whether entity or individual, has not been prohibited from participation in federal and state health care programs by doing a manual check of the Exclusion Lists on KChecks.

Once the relationship has been entered into, the VP Purchasing or a designee shall upload the name on KChecks on the ArchCare corporate account and resolve matches if necessary. KChecks will perform screening checks of the Exclusion Lists monthly thereafter.

#### **Locally-negotiated Business Arrangements**

For business relationships negotiated at the ArchCare Entity level, the Executive Director or a designee shall verify that any prospective vendor or contractor, whether entity or individual, has not been prohibited from participation in federal and state health care programs by performing a manual search of the Exclusion Lists on KChecks.

Once the relationship has been entered into, the Executive Director or a designee shall upload the name on KChecks and resolve matches if necessary. KChecks will perform screening checks of the Exclusion Lists monthly thereafter.

If the vendor or contract is entered on the M System, the name will be uploaded on KChecks by purchasing staff and matches will be resolved if necessary.

If a check request is completed, the name of the payee will be loaded on KChecks by the Entity Compliance Officer or Compliance Liaison and matches will be resolved if necessary. The Entity Compliance Officer or Compliance Liaison will print screen the result of the search for the individual completing the check request and that print screen will be attached to the check request and sent to Finance.

Screening for entities paid via credit card is the responsibility of the credit card holder.

#### **F. SCREENING OF REFERRING PROVIDERS.**

New Referring Providers. *Prior to accepting referrals, filling orders or prescriptions from, or furnishing items or services at the medical direction of, a referring provider who is new to ArchCare, ArchCare will, at minimum, manually check the name of each such individual or entity against each of the Exclusion Lists on Kchecks.*

62. Current Referring Providers. KChecks will perform screening checks of the Exclusion Lists monthly thereafter.

#### **G. SCREENING OF POTENTIAL AND CURRENT MEMBERS OF GOVERNING BODIES**

Prior to appointment, the applicant member of the governing bodies of ArchCare will be uploaded to the KChecks screening application by the Chief Compliance Officer. KChecks will perform screening checks of the Exclusion Lists monthly thereafter.

#### **A. RESULTS OF SCREENING**

If screening of the Exclusion Lists reveals, or it is otherwise discovered, that a potential employee, a new referring provider or a potential contractor is found to be an Ineligible individual/entity ArchCare will not hire, contract, become affiliated with or do business with, the individual or entity, and will not accept referrals, orders, prescriptions or direction from, any such Referring Provider.

2. If screening of the Exclusion Lists reveals, or it is otherwise discovered, that a current employee or contractor or a current referring provider is an Ineligible

individual/entity or is otherwise ineligible to continue to contract with an ArchCare entity, the name of the individual/entity and the reason for the ineligibility should be reported promptly to the appropriate Compliance Officer, Compliance Liaison or to the Chief Compliance Officer. In any event, the Chief Compliance Officer must be notified. ArchCare will take all appropriate corrective action.

This may include, but is not limited to, one or more of the following: suspension or termination of an individual's employment, affiliation or contract with, or work for, ArchCare; termination of a Vendor's contract; permanent suspension of claims that are related (directly or indirectly) to the Ineligible individual/entity; the timely return of monies improperly received, in accordance with applicable law, regulation, guidance and/or contract; and/or self-disclosure or reporting to the appropriate government agency(ies), or other payors, in accordance with applicable law, regulation, guidance and/or contract.

At minimum, an Ineligible individual/entity will be removed from any and all responsibility for, and any and all involvement with, Federal and state health care programs (including administrative and management services), and ArchCare will cease submitting claims to, or seeking or causing payments to be made from, Federal and state health care programs that relate in any way, whether directly or indirectly, to items or services provided by, at the medical direction of, or that result from an order, prescription, or referral from the Ineligible individual/entity, in accordance with applicable law, regulation and guidance.

Other appropriate corrective action, if necessary, may also be taken in accordance with ArchCare's Compliance and Ethics Program and its compliance policies and procedures.

## **I. COMPLIANCE OVERSIGHT**

Each ArchCare Entity's Compliance Officer or Compliance Liaison will monthly monitor all KChecks sites to ensure that there are no new unresolved matches and to ensure that all those matches have been reconciled and if any can't be reconciled.

Each ArchCare Entity's Compliance Officer or Compliance Liaison will check to ensure that the number of new employees from Human Resources matches the total number of employees newly uploaded onto the KChecks system.

## **B. MAINTENANCE OF DOCUMENTATION**

The search results page of the checks of the Exclusion Lists or other proof that the

required checks of the Exclusion Lists have been performed will be maintained by the Compliance Officer, Compliance Liaison or a designee. In addition, records of any investigations, corrective action, disciplinary action or other action taken in accordance with this Policy and Procedure will also be maintained by the Compliance Officer, Compliance Liaison, Chief Compliance Officer or a designee. All such documentation will be maintained for no less than ten (10) years from the later of: (a) the last date on which the Exclusion Lists were searched, (b) the conclusion of the investigation, (c) the imposition or ending date (as the case may be) of any corrective, disciplinary or other action, or (d) for such longer period of time as may be required by applicable law, regulation or contractual requirement.

#### REVISION HISTORY:

Date	Change/Note
4/23/2025	Removed exclusion screening for volunteers and students since providers and facilities aren't paying Medicare/Medicaid funds for these individuals.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes. Clearly defined that that state exclusions are also reviewed.
8/2022	Replaced "compliance program" with "compliance and ethics program" and replaced Board Compliance Committee with Board Audit, Risk, and Compliance Committee
8/2021	Expanded Policy, Definitions and Results of Screening sections. Added requirement that referring providers be checked against the exclusion lists. Added Documentation section.
10/2019	Added Compliance Oversight provisions in section G and added to Section E that governing body members are screened by KChecks each month after they are uploaded.
4/2019	Added provision about agency staff/temporary staff/consulting staff
12/2018	Added provision for HR to re-enter employee in KChecks at any time that an employee transfers from one ArchCare payroll to another. (See Procedure A.3.)
9/2018	Added provision for SVP, Compliance to enter governing body members prior to approval by Providence
6/2011	Changes to incorporate new process of exclusion screening
1/2011	Changes per annual review
7/08/2008	Original Policy

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

**SUBJECT:** Compliance and Ethics Program, Governing Body Members  
Education, System-Wide (System Wide)

**ORIGINATING DEPARTMENT:** Corporate Compliance

**Effective Date:** 09/15/2022

**BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL**  
**DATE:** 5/14/2025

**MOST RECENT REVIEW/REVISION DATE:** 4/23/2025

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**PURPOSE:** To provide effective compliance education and training to all members of ArchCare's governing bodies, who are considered affected individuals.<sup>28</sup>

**ENTITIES AFFECTED:** All ArchCare-sponsored entities

**SCOPE:** This policy applies to all ArchCare-sponsored Entities.

**RESPONSIBILITY:** The President and CEO, ArchCare, is responsible for notifying the Chief Compliance Officer of the appointment of a new governing body member. The Chief Compliance Officer is responsible for (i) ensuring that new governing body members receive compliance training and education upon their appointment; (ii) ensuring that all governing body members receive compliance training and education on an annual basis; and (iii) retaining records of such education.

**POLICY:** Within 30 days of appointment to an ArchCare governing body, a new member shall receive compliance training and education as part of orientation. Governing body members shall thereafter receive compliance education and training on an annual basis. Potential education and training topics may include, but are not limited to: (i) the elements of an effective Compliance and Ethics Program; (ii) the structure and operation of the ArchCare Compliance and Ethics Program (including, but not limited to: how and to whom to report issues, confidentiality, the investigation process, corrective actions,

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<sup>28</sup> As noted by Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

disciplinary policies, non-retaliation/non-intimidation policies); (iii) ArchCare's expectations for care members to abide by the Code of Conduct, report issues and assist in their resolution; (iv) laws and regulations regarding fraud, waste, and abuse in Federal health care programs (including the False Claims Act and other federal and state laws prohibiting the filing of false claims); (v) compliance risk areas; and (vi) the governing body's role and responsibilities as to oversight of the Compliance and Ethics Program.

Such education shall also meet the criteria set forth in Chapter 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual as it relates to Catholic Managed Long Term Care Inc. d/b/a ArchCare Senior Life (PACE).

#### **PROCEDURE:**

63. The Chief Compliance Officer shall ensure that governing body members receive compliance training and education either in person or via webinar. New governing body members should receive this training within 30 days of appointment. All governing body members must be trained annually.

64. After the completion of the educational session, the Chief Compliance Officer shall ensure that a signed attestation confirming the members' receipt of ArchCare's Code of Conduct, general compliance and FWA education is collected. See [Compliance and Ethics Program, Form, Attestation of Receipt of Compliance/FWA Education by Governing Body Members](#)

65. The Chief Compliance Officer shall ensure that the name of the new member is uploaded to the exclusion screening database as well as retain a copy of the initial exclusion check in the Compliance and Ethics Program files.

66. The Chief Compliance Officer shall retain the signed attestations accompanied by the education material for a period of 10 years in the Compliance and Ethics Program files.

67. The Chief Compliance Officer shall periodically (no less than annually) monitor, evaluate and assess the effectiveness of ArchCare's education and training programs and shall revise such programs as necessary.

#### **REVISION HISTORY:**

Date	Change/Note
4/23/2025	Annual review and update of the policy.
5/1/2024	Annual review and update of the policies.

5/1/2023	Review to align with the new OMIG Guidance. In addition, made formatting changes.
8/2022	Replaced “board compliance committee” with “board audit, risk, and compliance committee” and replaced “compliance program” with “compliance and ethics program”
8/2021	Expanded potential training topics. Revised the training schedule to within 30 days of appointment of a new member consistent with OMIG guidance. Emphasized the requirement for annual training. Added requirement to evaluate the training material.
10/03/2018	Policy implemented



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## ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Vendor Deficit Reduction Act  
Compliance Education, System-wide

ORIGINATING DEPARTMENT: Compliance

APPROVAL DATE: 09/15/2022

AUDIT, RISK & COMPLIANCE COMMITTEE APPROVAL DATE: 5/14/2025

MOST RECENT REVIEW/REVISION DATE: 4/23/2025

Version: 8

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**PURPOSE:** To comply with Section 6032 of the Deficit Reduction Act of 2005 by providing information to designated contractors about ArchCare's policies and procedures and certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs. This policy is extended by Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York.

**ENTITIES AFFECTED:** All ArchCare-sponsored entities

### DEFINITIONS:

**Designated Contractor:** Any contractor, subcontractor, agent, or other person which or who on behalf of ArchCare or an ArchCare Affiliated Entity furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the relevant Entity. This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

**POLICY:** It is the policy of ArchCare and its Affiliated Entities to provide health care services in a manner that complies with applicable federal and state law. To further this and to comply with Section 6032 of the Deficit Reduction Act of 2005 and Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York with regard to ArchCare

contractors with compliance responsibilities, ArchCare and its Affiliated Entities who are Medicaid providers require designated contractors to acknowledge receipt of and compliance with ArchCare's policies and procedures to prevent and detect fraud, waste, and abuse in federal health care programs.

Such acknowledgement will be accomplished by executing a certification. See [Compliance and Ethics Program, Vendor Packet for DRA Compliance](#)

## RESPONSIBILITIES/PROCEDURE

68. The senior official of each applicable ArchCare facility and program and senior ArchCare staff shall be jointly responsible for ensuring that operational procedures conform to this policy and that staff are aware of this policy and the Federal and State laws outlined in Appendix A.

69. The senior official of the applicable ArchCare facility or program shall be responsible for obtaining an executed DRA Certification if the vendor arrangement does not go through the contract review process.

70. ArchCare's agreement with a **Designated Contractor** should contain a provision enforcing execution of the certification, see [Compliance and Ethics Program, Contractor-Vendor Certification of Receipt of FWA Materials](#) and continued adherence to ArchCare's compliance policies. Example: To comply with the Employee Education Provision of the Deficit Reduction Act of 2005, Designated Contractor must execute a certification of receipt of information regarding fraud, waste, and abuse, and adhere to the compliance policies received from ArchCare, as updated from time to time on the corporate compliance tab of the archcare.org website. Designated Contractor must educate its employees and agents, on at least an annual basis, about the ArchCare Code of Conduct, and fraud, waste, and abuse issues including the False Claims Act and whistleblower protections provided thereunder, if such employees do not complete ArchCare's own New Employee Orientation and Reorientation.

## REVISION HISTORY:

Date	Change/Note
4/23/2025	Annual review of policy.
5/1/2024	Annual review and update of the policies and update the 2024 Federal penalty amounts.
6/27/2023	Review and update the 2023 Federal penalty amounts.
5/1/2023	Review and update to align with the new OMIG Guidance including extending the policy. In addition, made formatting changes.

8/2022	Replaced “board compliance committee” with “board audit, risk, and compliance committee” and replaced “compliance program” with compliance and ethics program”.
8/2021	Reorganized policy; Minor revisions.
4/2019	Revised responsibilities and procedure section to reflect current contract review process.
6/2014	Revised to note that education requirements for designated contractors must be met on at least an annual basis.
11/2011	Revised to replace Vendormate Registration requirement with requirement for vendors to certify receipt of vendor compliance package.
2/2011	Revised to require designated contractors to register with Vendormate to acknowledge receipt of Deficit Reduction Act Employee Education information and compliance with ArchCare’s policies and procedures to prevent and detect fraud, waste, and abuse in federal health care programs.
2/22/2008	Revised to ensure compliance with Employee Education provisions of the Deficit Reduction Act
9/6/2007	New Document

## APPENDIX A

### FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS/WHISTLEBLOWER PROTECTIONS

#### I. FEDERAL LAWS

##### A. False Claims Act [**Title 31 United States Code §§ 3729 to 3733**]

The False Claims Act (“FCA”) provides, in pertinent part, that:

Any person who (1) knowingly presents, or causes to be presented, to an office or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;...or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

\* \* \*

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000,<sup>29</sup> plus 3 times the amount of damages which the Government sustains because of the act of that person....

For purposes of this section:

(a) the term “claim”— means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—(i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government—

- provides or has provided any portion of the money or property requested or demanded; or
- will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
- does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal

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<sup>29</sup> Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between \$5,000 and \$10,000, those amounts have been adjusted for inflation. As of February 12, 2024, the minimum False Claims Act penalty will increase from \$13,508 to \$13,946 per claim, and the maximum penalty will increase from \$27,018 to \$27,894 per claim.

employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(b) The terms "knowing" and "knowingly" mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(c) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(d) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act.

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a *qui tam* relator, when the Government has intervened in the lawsuit, shall receive at least 15

percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

**B. Administrative Remedies for False Claims [Title 31 United States Code §§ 3801 to 3812]**

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to \$5,000 for each claim.<sup>30</sup> The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency not by prosecution in the federal court system.

**II. NEW YORK STATE LAWS**

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

**A. Civil and Administrative Laws**

**NY False Claims Act [State Finance Law §§187–194]**

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is equal to the amount that may be imposed under the federal FCA (as may be adjusted for inflation) and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were

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<sup>30</sup> Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between \$5,000 and \$10,000, those amounts have been adjusted for inflation. As of February 12, 2024, the minimum False Claims Act penalty will increase from \$13,508 to \$13,946 per claim, and the maximum penalty will increase from \$27,018 to \$27,894 per claim.

state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover up to 25-30% of the proceeds.

### **Social Services 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 three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$10,000 per violation. If repeat violations occur within 5 years, a penalty up to \$ 30,000 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

### **Social Services 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, the person's family's needs are not taken into account for six months if a first offense, 12 months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

## **B. Criminal Laws**

### **Social Services 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 Services Law § 366-b – Penalties for Fraudulent Practices**

- a. 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.
- b. Any person, who with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services 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 his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

- c. Fourth degree grand larceny involves property valued over \$1,000. It is a Class E felony.
- d. Third degree grand larceny involves property valued over \$3,000. It is a Class D felony.
- e. Second degree grand larceny involves property valued over \$50,000. It is a Class C felony.
- f. First degree grand larceny involves property valued over \$1 million. It is a Class B felony.

### **Penal Law Article 175, False Written Statements**

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

- g. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.
- h. §175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.
- i. §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.
- j. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

### **Penal Law Article 176, Insurance Fraud**

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

- k. Insurance fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.



- l. Insurance fraud in the 4<sup>th</sup> degree is filing a false insurance claim for over \$1,000. It is a Class E felony.
- m. Insurance fraud in the 3<sup>rd</sup> degree is filing a false insurance claim for over \$3,000. It is a Class D felony.
- n. Insurance fraud in the 2<sup>nd</sup> degree is filing a false insurance claim for over \$50,000. It is a Class C felony.
- o. Insurance fraud in the 1<sup>st</sup> degree is filing a false insurance claim for over \$1 million. It is a Class B felony.
- p. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

### **Penal Law Article 177, Health Care Fraud**

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

- q. Health care fraud in the 5<sup>th</sup> degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
- r. Health care fraud in the 4<sup>th</sup> degree is filing false claims and annually receiving over \$3,000 in aggregate. It is a Class E felony.
- s. Health care fraud in the 3<sup>rd</sup> degree is filing false claims and annually receiving over \$10,000 in the aggregate. It is a Class D felony.
- t. Health care fraud in the 2<sup>nd</sup> degree is filing false claims and annually receiving over \$50,000 in the aggregate. It is a Class C felony.
- u. Health care fraud in the 1<sup>st</sup> degree is filing false claims and annually receiving over \$1 million in the aggregate. It is a Class B felony.

### **III. WHISTLEBLOWER PROTECTIONS**

#### **A. Federal False Claims Act (31 U.S.C. §3730(h))**

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special

damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

B. NY False Claim Act **[State Finance Law § 191—Remedies]**

The New York False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

C. New York Labor Law §740

An employer may not take any retaliatory 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. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an 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 health 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.

D. New York Labor Law §741

Certain health care employers 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, to a news media outlet or to a social media forum available to the public at large. 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. The employee's disclosure is protected 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, a specific patient or a specific employee and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an 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 health 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.

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## ARCHCARE AND AFFILIATED ENTITIES POLICY

**SUBJECT:** Compliance and Ethics Program, Compliance and Ethics Program Training & Education, System-Wide

**ORIGINATING DEPARTMENT:** Compliance

**Original Effective Date:** March 1, 2011

**Most Recent Review/Revision Date:** 4/24/2025

**Board Audit, Risk, and Compliance Committee Approval:** 5/14/2025

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**PURPOSE:** All ArchCare-sponsored Entities will provide effective compliance training and education to all care members and associates.

**ENTITIES AFFECTED:** All ArchCare-Sponsored entities

**SCOPE:** This policy applies to the workforce<sup>31</sup> of ArchCare and its affiliated entities. Specifically, ArchCare “workforce” includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term “workforce” also applies to contractors, subcontractors, agents and independent contractors who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare. In addition, this policy extends to the governing body and corporate officers.

### **POLICY:**

71. ArchCare-sponsored Entities will provide compliance education and training to each workforce member, including the Compliance Officer or Compliance Liaison, the Chief Executive and other senior administrators and managers, as part of the care member’s

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<sup>31</sup> This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines “[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider’s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.”

orientation (within 30 days of hire) and annually thereafter in its NEO and REO eLearning.

72. The following affected individuals will either complete the compliance New Employee Orientation/Annual Reorientation or receive an annual packet containing the vendor training, links to the ArchCare Policies and Procedures, Compliance Charter and any other relevant compliance documents. They may be asked to complete an attestation of review the documents:

- a. Affiliated medical and allied professional staff,
- b. Students,
- c. Volunteers,
- d. Agency Staff,
- e. Temporary Staff, or
- f. Consultant Staff.

73. ArchCare vendors who do not have patient contact and do not work inside an ArchCare facility but who: 1) furnish federal health care program (*e.g.*, Medicare or Medicaid) health care items or services; 2) perform billing or coding functions, 3) monitor healthcare provided by ArchCare; 4) perform other tasks on behalf of ArchCare necessitating compliance education as determined by the Chief Compliance Officer; or 5) who have been identified as an “affected individuals” must receive an annual packet containing the vendor training, links to the ArchCare Policies and Procedures, Compliance Charter and any other relevant compliance documents. They may be asked to complete an attestation of review the documents. See [Compliance and Ethics Program, Vendor Deficit Reduction Act Compliance Education, System-wide](#). Entity Compliance Officers or Compliance Liaisons or their designees must spot check vendor records to ensure compliance with this requirement.

74. All training will be conducted per Annual Training Plan.

75. ArchCare-sponsored programs or plans that administer Medicare Parts C & D benefits require that care members and First Tier, Downstream, and Affiliated Entities receive CMS Compliance and FWA or its equivalent. The requirement to complete FWA is also extended to First Tier, Downstream, and Affiliated Entities of MLTC plans. Providers will receive an annual packet containing provider training, links to the ArchCare Policies and Procedures, Compliance Charter, Special Investigation Policy,

FWA Prevention Plan and any other relevant compliance documents. They may be asked to complete an attestation of review the documents.

76. Potential education and training topics may include, but are not limited to: (i) the elements of an effective Compliance and Ethics Program; (ii) the structure and operation of the ArchCare Compliance and Ethics Program (including, but not limited to: how and to whom to report issues, confidentiality, the investigation process, corrective actions, disciplinary policies, non-retaliation/non-intimidation policies); (iii) ArchCare's expectations for care members to abide by the Code of Conduct, report issues and assist in their resolution; (iv) laws and regulations regarding fraud, waste, and abuse in Federal health care programs (including the False Claims Act and other federal and state laws prohibiting the filing of false claims);<sup>32</sup> and (v) compliance risk areas.

77. Completing such compliance training and education annually is mandatory and is a condition of continuing employment by, association with or conducting business with ArchCare and its Affiliated Entities.

## PROCEDURE

2. Registrations of New Employee Orientation and Annual Reorientation e-learning shall be maintained by the Human Resources department and/or Staff Development and shall be reported to the appropriate Compliance Committee.

78. The Chief Compliance Officer, Compliance Liaisons, Compliance Officers and other appropriate officers, managers and supervisors will be available on a continuing basis to answer questions from care members who seek clarification regarding compliance issues.

79. Educational and training files, including copies of all written materials, shall be retained for a period of no fewer than ten (10) years from the date the materials were last used.

80. The Chief Compliance Officer shall periodically (no less than annually) monitor, evaluate and assess the effectiveness of ArchCare's education and training programs and shall revise such programs as necessary.

## REVISION HISTORY

Date	Change/Note
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<sup>32</sup> Attached to this Policy as Appendix A is an overview of the federal and state false claims laws, state criminal, civil and administrative penalties for filing false claims, and the whistleblower protections afforded by such laws.

4/24/2025	Annual review and update of policy
5/1/2024	Annual review and update of the policies and update the 2024 Federal penalty amounts.
6/27/2023	Review and update the 2023 Federal penalty amounts.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	replaced compliance with compliance and ethics
8/2021	expanded potential training topics; specified employees that must be trained in accordance with SSL 363-d and that training should take place with 30 days of hire; added procedure section, including requirement for retaining records and evaluating effectiveness of the training. Updated Appendix A, deleted reference to OMIG and privacy training.
4/2019	added Agency Staff, Temporary Staff, Consultant Staff to section 3 d;
11/2018	added temporary employees to “associates” and specified that compliance training must take place within 90 days of hire;
3/2017	clarified who is included in “associates”;
1/2011	Changes per annual review;
9/6/2007	new policy

## APPENDIX A

### FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS/WHISTLEBLOWER PROTECTIONS

#### FEDERAL LAWS

##### False Claims Act [Title 31 United States Code §§ 3729 to 3733]

The False Claims Act (“FCA”) provides, in pertinent part, that:

Any person who (1) knowingly presents, or causes to be presented, to an office or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;...or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

\* \* \*

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000,<sup>33</sup> plus 3 times the amount of damages which the Government sustains because of the act of that person....

For purposes of this section:

(a) the term “claim” — means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—(i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government—

- provides or has provided any portion of the money or property requested or demanded; or
- will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
- does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual’s use of the money or property;

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<sup>33</sup> Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between \$5,000 and \$10,000, those amounts have been adjusted for inflation. As of February 12, 2024, the minimum False Claims Act penalty will increase from \$13,508 to \$13,946 per claim, and the maximum penalty will increase from \$27,018 to \$27,894 per claim.



(b) The terms “knowing” and “knowingly” mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(c) the term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor- licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(d) the term “material” means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act.

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. These private parties, known as “*qui tam* relators,” may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a *qui tam* relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon

the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

### **Administrative Remedies for False Claims [Title 31 United States Code §§ 3801 to 3812]**

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to \$5,000 for each claim.<sup>34</sup> The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency not by prosecution in the federal court system.

## **NEW YORK STATE LAWS**

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

### **Civil and Administrative Laws**

#### **NY False Claims Act [State Finance Law §§187–194]**

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is equal to the amount that may be imposed under the federal FCA (as may be adjusted for inflation) and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to

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the government, the person who started the case can recover up to 25-30% of the proceeds.

#### **Social Services 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 three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$10,000 per violation. If repeat violations occur within 5 years, a penalty up to \$ 30,000 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

#### **Social Services 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, the person's family's needs are not taken into account for six months if a first offense, 12 months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

### **Criminal Laws**

#### **Social Services 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 Services Law § 366-b – Penalties for Fraudulent Practices**

- b. 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.
- c. Any person, who with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services 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 his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

d. Fourth degree grand larceny involves property valued over \$1,000. It is a Class E felony.

e. Third degree grand larceny involves property valued over \$3,000. It is a Class D felony.

Second degree grand larceny involves property valued over \$50,000. It is a Class C felony.

f. First degree grand larceny involves property valued over \$1 million. It is a Class B felony.

### **Penal Law Article 175, False Written Statements**

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

g. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

h. §175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

§175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

i. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

### **Penal Law Article 176, Insurance Fraud**

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

j. Insurance fraud in the 5<sup>th</sup> degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

k. Insurance fraud in the 4<sup>th</sup> degree is filing a false insurance claim for over \$1,000. It is a Class E felony.

Insurance fraud in the 3<sup>rd</sup> degree is filing a false insurance claim for over \$3,000. It is a Class D felony.

l. Insurance fraud in the 2<sup>nd</sup> degree is filing a false insurance claim for over \$50,000. It is a Class C felony.

Insurance fraud in the 1<sup>st</sup> degree is filing a false insurance claim for over \$1 million. It is a Class B felony.

m. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

### **Penal Law Article 177, Health Care Fraud**

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

n. Health care fraud in the 5<sup>th</sup> degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

o. Health care fraud in the 4<sup>th</sup> degree is filing false claims and annually receiving over \$3,000 in aggregate. It is a Class E felony.

Health care fraud in the 3<sup>rd</sup> degree is filing false claims and annually receiving over \$10,000 in the aggregate. It is a Class D felony.

p. Health care fraud in the 2<sup>nd</sup> degree is filing false claims and annually receiving over \$50,000 in the aggregate. It is a Class C felony.

Health care fraud in the 1<sup>st</sup> degree is filing false claims and annually receiving over \$1 million in the aggregate. It is a Class B felony.

## **3. WHISTLEBLOWER PROTECTIONS**

## **Federal False Claims Act (31 U.S.C. §3730(h))**

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

## **NY False Claim Act**

The New York False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

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Certain health care employers 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, to a news media outlet or to a social media forum available to the public at large. 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. The employee's disclosure is protected 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, a specific patient or a specific employee and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an 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 health 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.