Head Injury Association Compliance and Quality Improvement Work Plan 2024

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I. Introduction

The Head Injury Association Compliance and Quality Improvement process is based upon Federal and State Regulations. This process has been formulated to conduct scheduled reviews based on regulatory requirements at the department level to ascertain the facility's level of regulatory compliance. Issues identified as areas requiring improvement are brought to the Head Injury Association Leadership Committee and Compliance Committee, respectively, for process and system review, revision of current practices and policies to improve overall outcomes. The Head Injury Association Compliance and Quality Improvement Work Plan is not all inclusive. Other procedures should be referred to including the Risk Management Assessment, HIPAA Compliance Policies and Head Injury Association Safety Manual.

The intention of such a process is to compliment administrative activities at all program sites to maintain current Head Injury Association standards of care. In addition to this basic foundation set fourth by Head Injury Association's Mission, data is collected from prior New York State Office of Persons with Developmental Disabilities (NYS OPWDD) fiscal, re-certification and annual reviews, emphasis being placed on citations common to particular reviewers and specific to Head Injury Association's protocols and procedures. The information can be used as a tool to maintain the quality of Head Injury Association's services and to prepare for a fiscal, re-certification or annual review conducted by external agencies.

The review process, applies to all of the services that Head Injury Association provides be they long-term residential services, day time service alternatives, service coordination or other family support services. Additionally, the manual includes sections on each individual *Internal Review Protocols* and samples of staff training provided, all developed to meet Head Injury Association standards in addition to exceeding current universal protocols provided to volunteer agencies by NYS OPWDD. Each program protocol has been enhanced with specific billable unit descriptions for that particular program and information pertaining to the variety of documentation required to justify billing for services rendered.

As a team we work together to fulfill Head Injury Association's mission to, "To ensure that survivors of head injury maximize their potential for recovery and are provided the necessary tools to achieve the valued outcomes of Individualization, Independence, Integrations and Productivity." Emphasis placed on discovery, remediation and improvement corroborates Head Injury Association's dedication to continuous quality management. Our goal is that the information presented in training sessions, gathered during on-going activities and resulting Annual Report to the Executive Director will be used as a reference point as to how we currently operate today in order to improve how we carry out our mission tomorrow.

II. Providing Direction and Support

Governance

The KINEXION governance contributes to the success of our mission to stand as an operational model of excellence and sustainability, equipping our network providers with the financial strength and resources to deliver lifetime care. The role of the Boards of Directors is to:

- Govern our affiliate providers by establishing broad goals and objectives.
- Select, appoint, support, and review the performance of the Executive Directors.
- Ensure the availability of adequate financial resources.
- Approve annual budgets and strategic planning.
- Account for the ethics, compliance, and performance of the affiliate providers.

Leadership Committee

Chaired by Head Injury Association's Executive Director, members include senior management from every HIA department and may also include Kinexion Administrative Staff or Affiliate Executive Directors. In order to facilitate the developed systemic checks and balances and prevent future occurrences, data gathered while completing each Internal Quality Assurance Review will be shared with the appropriate program representatives. A uniform package of reports relying on specific criteria analyzed, identifying positive aspects of programming at each site and including recommendations for improvement, is developed by the Department of Quality Assurance. Dissemination of information will be timely and thorough to ensure corrective actions are taken in a reasonable amount of time. The process includes an immediate verbal review of all findings, followed by a written report regarding said findings and recommendations to initiate systemic changes in deficient areas. A summary of findings report is provided to all relevant program representatives in addition to all relevant administrators, including but not limited to, The VP of Residential Services, the Director of Day Program Services and the Executive Director. All review protocols are distributed the program Directors, Assistant Directors and to all relevant staff.

The Corporate Compliance Committee

The Corporate Compliance Committee works in collaboration with the Compliance Officer to review and revise policies and procedures, investigate/document allegations and implement/review/revise the Head Injury Association Compliance and Quality Improvement Work Plan.

The Corporate Compliance Committee includes a diversified membership that includes a cross-section of each department. Members include, but are not limited to, senior level management, representatives from major services, representatives from Human Resources and representative from the Board of Directors. The Board of Director member has been chosen by the Board of Directors to represent the governing body at the local level. It is assumed that their involvement in the review of the Head Injury Association Compliance and Quality Improvement Work Plan would represent approval of the Board of Directors.

Meetings are held regularly (quarterly or more often if needed). Minutes are recorded and maintained. The minutes are shared with Head Injury Association's Executive Director for reporting purposes. An annual report is developed and shared with Head Injury Association's Executive Director for reporting to the Board of Directors.

III. Desired Agency Achievements

As Head Injury Association expands its services, it becomes even more important that we continue to be proactive in our efforts to continue to provide the services that are best suited for those receiving services. Active monitoring and auditing internal data reflected in our performance in external review is relevant to the overall review environment in which we operate.

As we all know, more and more scrutiny is being placed on State and Federal sponsored programs from all levels of government, more and more regulations are being implemented and those existing regulations are being interpreted more and more conservatively.

The following Agency Achievements have been developed to assist reaching Head Injury Association's benchmarks.

- To assure the appropriateness, adequacy, effectiveness and quality of care and services through a systematic program of planning, measurement, assessment, and improvement.
- Contribute to improving, and ultimately achieving, core staff performance standards by assisting in staff development.
- To ensure compliance with regulatory, licensing and accreditation agencies.
- To encourage timely identification and resolution of deficient areas.
- Assist in creating and maintain a positive environment for service recipients, families and staff.
- Provide training and assistance in order to develop support staff who use positive approaches to supporting service recipients and their families.
- Involve families and advocates in improving service delivery.
- Encourage accountability.
- Reduce the number of injuries by keeping people safe through training initiatives.
- Ensure the 'Person Centered' plan development.
- Maintain program accessibility.
- To ultimately improve the quality of life/quality of care for each individual receiving services

IV. Quality Achievement Processes-Quality Assurance Internal Reviews

Environmental and Safety Review

The *Environmental and Safety Review tool* is used to gain information regarding the current overall condition of Head Injury Association program sites, otherwise identified as physical plant. Although not all program sites operated by Head Injury Association are regulated by the National Fire Prevention Association (NFPA) Life Safety Code standards, attention is placed on these regulations to ensure the safety and well-being of all of the consumers served by Head Injury Association at all program sites. In addition, this process assists in identifying various sites where attention is needed to maintain Head Injury Association's standards regarding the priority of the health and safety of the people we support. Other areas where attention is placed when completing the environmental and safety reviews include various in-service topics and fire evacuation planning.

The *Environmental and Safety Review tool* was designed to ensure the facility remains assessable, safe, clean, well maintained and free from hazardous conditions. Although the reviews are usually unannounced, the reviewer will schedule a time throughout the day to accommodate the attendance of various administrative staff or maintenance staff if preferred. The *Environmental and Safety Review tool* is designed to assist in continuing to maintain all Head Injury Association's operated program sites and decrease the number of citations received during NYS OPWDD reviews gained from physical plant assessment conducted by the NYS Office of Fire Prevention and Control (OFPC).

In-service topics reviewed include infectious control, universal precautions, regulated wastes, emergency medical procedures and medication storage. Regulations require that all staff have knowledge of the significant risks associated with exposure to bodily fluids. All staff should be utilizing universal

precautions to prevent the spread of infection, be aware of medication storage guidelines and understand emergency procedures in the event they must be implemented.

Record Review

The *Head Injury Association's Quality Assurance Internal Review Protocols* were designed to ensure that professional and regulatory commitments are being met in all program areas. These include Head Injury Association's commitment to providing quality services in all areas. Specifically, continued fiscal responsibility, individualized program planning and comprehensive medical care. During the visit, occurring at least annually, a sample of completed individual records will be reviewed. Documents viewed while completing a core documentation review include primary central planning documents (Life Plan/Staff Action Plan), documentation records, clinical documents, medical related documents and progress notes. A range of ages, abilities, admission status and interests will be taken into consideration when choosing the sample.

Safeguarding Personal Allowance

Additional financial management responsibilities accepted by Head Injury Association include insuring that a person receives his/her Personal Allowance. This area is reviewed by a Head Injury Association representative utilizing the *Head Injury Association Personal Allowance Internal Review Protocol*. How the individuals we serve spend their money, or how you spend it on their behalf based on their input, must also reflect the individuals' preferences and choice. As Personal Allowance comes from government benefits it's very important the person should not lose the benefits. The person's income and assets must be tracked to ensure the person remains qualified. Total assets must be kept within the limits of corresponding entitlements.

All persons who receive personal allowance via Head Injury Association must have a Personal Expenditure Plan (PEP). The PEP establishes the person's resources over the next twelve months, includes personal shopping or luxury items intended for purchase in addition to other identified expenses. The PEP must be reviewed on at least an annual basis for each person. Funds must be received in a timely manner. It is also required that these funds be used properly, only for the personal needs of the individual. All ledgers must be maintained by Head Injury Association's standards, reflecting the receipt and disbursement of all funds and matching the balance of cash on hand. The person receiving the benefits should be supported in initialing the ledgers where they have the capacity to do so, giving them every opportunity for independence. Any misuse of personal allowance funds outside of the laws may be identified during the internal review.

The Department of Quality Assurance tracks and ensure that a 25% review is conducted through the Program Review Process. It remains the responsibility of the Residential Directors to review the Personal Allowance monthly. QA has instituted quarterly reviews and training on Personal Allowance of each assigned site. New Management staff are trained by QA on Personal Allowance in the first 90 day of employment before funds are turned over

Programmatic Observation

The *Quality Assurance Observation Report* is used as a guide when developing a final summary of the observation period. It is a tool used to assess the ability of staff to implement various protocols in which they have been trained as employees of Head Injury Association. In addition, understanding of best

practices when managing situations as they arise and positively contributing to the environment. It is also helpful in determining if adequate numbers of staff are available to meet the needs of individuals in each environment.

The time this observation period focuses on may be determined by deficiencies noted from pervious NYS OPWDD reviews, information gathered regarding NYS OPWDD auditor's preferences and areas of concentration following an audit at another program earlier in the year. It may also be determined by recommendations made by administration. However, areas of concentration will specifically be placed on active treatment, privacy preservation, medication administration and review of various protocols identified while performing record reviews to ensure they are being implemented as per Head Injury Association principles. Recently additional efforts have been placed on the importance of providing every individual with personal protection. This is a topic of great awareness and staff should be prepared for questions assessing their knowledge of individual rights. Employees should be trained on implementing strategies to protect such rights.

The reviewer's principle focus will be placed on the overall implementation of guidelines provided to the agencies. They will direct their attention to what actually happens while completing observations. They will measure how competently and effectively the program staff interact with the persons served, how physically well the individuals are and how clean and pleasant the physical surroundings. Staff should be confident in their abilities to perform all responsibilities on the day of the audit as they do daily.

V. Performance Measures

Although safety of the participants is the first and utmost priority of Head Injury Association, continuous learning to promote not only individual and effective services, but accountability is provided to all Head Injury Association employees at various times during their employment. In addition to rigorous internal review, various initiatives have continued to preserve the quality of all services. The Annual Report to the Executive Director will contain the progress made to meet agency initiatives. This includes, but are not limited to:

- Protect the health and safety of those we support;
- Continue to provide the most individualized and comprehensive medical care;
- Reducing the use of SCIP-R techniques;
- Reducing the number of regulatory deficiencies as a result of external surveys;
- Improving workforce through training initiatives;
- Safeguarding funding received;

Incident Reporting

Maintaining Reportable Incident Reports and related documentation is the responsibility of the Head Injury Association's Quality Assurance Department. The primary function of the incident review process is to enable necessary representatives to become aware of problems, to take corrective measures and to minimize the potential for recurrence of the same or similar events or situations. All strategies developed to prevent incidents from reoccurring will be reviewed to ensure all commitments and monitoring plan guidelines are being met. Incidents reports from the previous survey cycle will be reviewed to ensure that Head Injury Association is compliant with all regulations. Should an issue be identified while reviewing the Incident Review Process, this will be reviewed by the Quality Assurance Department in addition to the Incident Review Committee.

Limited Fiscal Review

A Limited Fiscal Review will be done in coordination with the program success review at all HCBS Waiver program sites. This process is retrospective in nature and designed to review all documentation to ensure that program documentation meets NYS OPWDD fiscal review standards. The Head Injury Association's *Limited Fiscal Review Protocol* will also be used to ensure that there is clear documentation of services rendered to justify the completed billing.

Staff Training

Head Injury Association ensures that all employees receive support in order to promote an organizational culture that encourages ethical conduct and commitment to compliance with the law. Focus is to ensure the services received by the consumers meet current Head Injury Association's professional commitments in addition to meeting all quality and fiscal requirements. Staff training providing compliance guidance is provided during mandated initial orientation regularly by supervisors responsible for each program. Periodic training is offered by the Quality Assurance Department in response to compliance issues as they arise.

Written policies and procedures are available to staff upon hire and on an ongoing basis throughout the year. New updates, tied to identified vulnerabilities and/or changes in regulations and policy are published as all policies and procedures are regularly and systematically reviewed/updated. There are policies and procedures in place to support staff training.

The Training Coordinator, Program Managers will track OPWDD mandatory training for each of their staff to keep people safe. These mandatory trainings include CPR, First Aid, SCIP, Choking Prevention, Abuse Prevention and Reporting, AMAP, etc., it can potentially lead to serious health concerns. The tracking system will be reviewed by QA during internal reviews to ensure compliancc.

Staff Retention

The Human Resources Department tracks and reviews staffing/onboarding with the Compliance committee quarterly. HR will be focusing on tracking recruitment efforts to determine activities that achieve desired results. Baseline data to be reviewed and strategies identified to improve performance.

HIA offers new hire Orientation every other week on a 3-day basis, to facilitate and expedite onboarding.

As part of HIA'S plan to retain staff, HR will be reviewing additional enhancements, including but not limited to:

Survey check-ins

Follow-up with new staff

Exit interviews are conducted to gain information on what can help in the future.

Administrative Oversight of Policies & Procedures

The Oversight and monitoring of Agency Policies has been charged to senior administration. Policy reviews are now assigned to the Agency's Policy Review Committee which was formed in late 2023. The Policy Review Committee is responsible for the review and approval of all policies. The committee's responsibility is the review of policies by the specific discipline. Finalized Policies are maintained in the

Executive office. A centralized database for staff access has yet to be determined. In addition, the Compliance Officer will ensure that all related policies are provided and/or available to all 'Key Persons', Vendors and Contractors.

Safe Patient Handling

The Safe Patient Handling Committee will continue to address topics of focus through review of data and publishing informative flyers, training and other forms of communication with staff in hopes of preventing future occurrences. Policies will be developed to ensure that all areas of client care and protections are addressed systemically.

Ongoing oversight of the Safe Patient Handling Committee is completed by the Chief Health Administrator.

Self-Advocacy

The Self-Advocacy Committee was formed in early 2024 to support the empowerment of individuals in all aspects of their lives. Individuals advocated and nominated respective person(s) for the oversight and chairing of the committee. Meetings have been designated to occur monthly, with meeting minutes maintained by the moderators. Individual involvement in hiring practices and on IRC are still being explored.

VI. Satisfaction Surveys

Another way in which Head Injury Association evaluates the agency's efforts toward our mission is by implementing an annual Services Satisfaction Survey process with those we serve. HIA's 'Services Satisfaction Surveys' are provided to those we support with the goal of insuring that all service recipients are given an opportunity to provide feedback on an annual basis.

Satisfaction Surveys are sent or given to individuals that use the full range of Head Injury Association's programs and services. The Survey provides the respondent the opportunity to express their level of satisfaction with the specific HIA service they receive, the staff that provide those services and their view of the overall quality of HIA programs and services.

Survey responses continue to provide us with validation that our programs and services continue to be considered of the highest quality; providing access to activities and opportunities that are specifically designed to meet the needs of each consumer based upon their individual needs.

Head Injury Association
Compliance Handbook

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This Compliance Handbook sets forth standards of conduct that all personnel employed by or associated with Head Injury Association are expected to follow. It is designed to be a guide and resource to help all personnel ensure that all business-related activities are conducted in compliance with all related laws and regulations.

The Compliance Program is designed to support and reinforce these efforts and help ensure that we continue to meet our own high expectations. The standards of conduct set forth in this Handbook often exceed those required by law. This is consistent with our commitment to uphold the highest standards of ethical conduct. The standards of conduct, however, cannot cover every situation that our personnel might face. The Program requires everyone -- from employees and consultants to members of the Board of Directors -- to continue to adhere to the highest legal and ethical standards of behavior. It is the responsibility of each employee or associated person acting as agents of Head Injury Association to learn, understand and obey the laws. If you are unsure of what a proper course of conduct might be in a specific situation, or believe that the standards of conduct set forth in this Handbook may have been violated, you are urged to contact the respective 'Compliance Officer.'

Head Injury Association
Corporate Compliance hotline: 631-543-2245 ext. 4045

Should an employee or agent feel making confidential inquires or reports is necessary, it should be noted that anonymity is different from confidentiality. A caller who requests anonymity does not identify themselves. A caller who requests confidentiality does identify themselves. The identity is not disclosed unless under circumstances related to court order.

An effective Corporate Compliance Program requires the input, leadership and commitment of the Senior Management and the Board of Directors to address and minimize the risk of regulatory non-compliance. The Corporate Compliance handbook is presented to the Board of Directors for approval, annually. Each Affiliate agency will develop its own *Quality and Compliance Improvement Plan*, inclusive of all activities designed to meet both regulatory and quality standards. Agency audit protocols are provided to the Executive Director and the local Corporate Compliance Committee for review annually, or as changes occur. Having a compliance program will thus help protect the institution should individual misconduct be discovered. as well as the ultimate penalty -- exclusion as a provider under Federal entitlement programs. We believe and expect that our Compliance Plan meets all of these requirements of the Federal Sentencing Guidelines. We expect it to be an effective and established part of our corporate culture, demonstrating our continuing commitment to the highest legal and ethical standards.

STANDARDS OF CONDUCT

This Code of Conduct sets forth the standards of conduct that all personnel are expected to follow. Everyone is required to adhere both to the spirit and the language of the Code, to maintain a high level of integrity in their business conduct, and to avoid any conduct that could reasonably be expected to reflect adversely upon the integrity or reputation of Head Injury Association.

Head Injury Association (HIA) is committed to preventing the occurrence if unethical or unlawful behavior, stopping such behavior as soon as possible after discovery, and to discipline employees who violate the Code, including employees who neglect to report a violation.

All employees must comply with this Code, immediately report any alleged violations of wrongdoing, and assist management and compliance personnel in investigating allegation of wrongdoing.

While these standards addressed in the Code of Conduct are intended to guide employees in the course of their day-to-day responsibilities, they do not replace any HIA program policies and procedures. There may be instances that are not addressed by the Code of Conduct or existing policies and procedures, or activities that may conflict with these standards. Employees must seek direction from their supervisor , other HIA management staff or the Compliance Officer in these instances.

All personnel associated with Head Injury Association must avoid all illegal conduct, both in business and personal matters, and should take no action that he or she believes is in violation of any statute, rule, or regulation. In addition, all personnel must adhere to the spirit and language of the standards of conduct set forth in this Handbook, must strive to avoid even the appearance of impropriety, and must never act in a dishonest or misleading manner when dealing with others. All personnel must also report to the appropriate Compliance Officer any potentially unethical or illegal conduct. All personnel are thus required to be familiar with the legal and ethical rules that govern their work. They are expected to acquire this knowledge by attending training sessions and by raising any questions or uncertainties about compliance issues with their supervisors or the Compliance Officer.

Business Practices

Head Injury Association personnel must never make any misrepresentations, dishonest statements, or statements intended to mislead or misinform. If it appears that anything you have said has been misunderstood, correct it promptly. In addition, management must ensure that all business records are accurate and truthful, with no material omissions or misstatements; that the assets and liabilities of Head Injury Association are accounted for properly in compliance with all tax and financial reporting requirements; and that no false records are made. Similarly, all reports submitted to governmental agencies, insurance carriers, or other entities will be accurately and honestly made.

Written Policies and Procedures

Individualized written policies and procedures based on current laws, regulations and practices to provide direction and guidance to staff. All employees, contractors and agents are required to adhere to them. These policies and procedures will be updated as laws and regulations change and as necessary based on results of internal or external audits or reviews.

Coding, Billing, and Claims Development and Submission

Training and education, including written and/or electronic resources and supervisory support, will be provided to all staff members involved with coding, billing, and other claims activities, so that they can successfully perform their job functions. In addition, governmentally designated high-risk activities shall be monitored and audited in a manner and with a frequency that will reasonably ensure that such activities are being properly and accurately performed.

Conflict of Interest Rules

The relationship between Head Injury Association and all of our personnel is one which carries with it a duty of honesty, loyalty and fidelity. Employees may not engage in any conduct that conflicts or is perceived to conflict with the best interest of HIA. Employees must disclose any circumstances where the employee or his or her immediate family member is an employee, consultant, owner, contractor, or investor in any entity that (i) engages in any business or maintains any relationship with HIA; (ii) provides to, or receives from, HIA any individual served referrals; or (iii) competes with HIA. Employees may not without permission of the Executive Director accept, solicit or offer anything of value from anyone doing business with HIA.

Employees and contractors must not allow any outside financial interest, or competing personal interest to influence their decisions or actions taken on behalf of HIA. Employees and contractors must avoid any situation where a conflict of interest exists or might appear between their personal interests and those of HIA. The appearance of a conflict of interest may be as serious as an actual conflict of interest.

All personnel must exercise the utmost good faith in all transactions which touch upon their duties and responsibilities for, or on behalf, of Head Injury Association. Even the appearance of illegality, of impropriety, or of a conflict of interest or duality of interest can be detrimental to Head Injury Association, and therefore must be avoided. All Head Injury Association Senior Administrative Personnel and '*Key-*

Persons' must complete a conflict of interest form in which they are required to disclose all direct and familial interests which compete or do business with Head Injury Association. In addition, all personnel must examine their own and their immediate family's activities, and promptly report to the Compliance Officer the existence of any enterprises in which they or their immediate family has an "interest," and which the person knows is engaged, or is reasonably likely to engage, in transactions with Head Injury Association.

Annual Disclosure of Conflicts of Interests

All Head Injury Association personnel who are in a position to influence any substantive business decision by Head Injury Association will, at least annually, file a Conflict of Interest Disclosure Statement with the Compliance Officer. The Compliance Officer will keep a confidential file of these Statements and will consult with outside counsel for the purpose of receiving appropriate legal advice for Head Injury Association concerning any potential problems or possible conflicts of interest. In addition, all personnel must also immediately disclose to the Compliance Officer any possible conflicts of interest as they arise. The Compliance Officer, as appropriate and necessary, will then consult with outside counsel. Such continuing disclosure should occur upon finding that the personnel or his or her immediate family have an interest or possible interest in an enterprise that might create a possible conflict of interest (as discussed above); upon entering into any outside relationship which might involve a conflict of interest with or cause embarrassment to Head Injury Association; or upon considering assuming such interests or outside relationships. If personnel are in doubt whether disclosure is required in a specific instance, they should err on the side of disclosure and immediately make all the facts known to the Compliance Officer. Upon receiving a disclosure of a possible conflict of interest, the Compliance Officer will review the disclosure, consult with counsel as appropriate, and determine if such financial interest or outside relationship creates a conflict of interest, is improper, or creates the appearance of a conflict of interest or of improper conduct. The Compliance Officer will also review the information disclosed to determine if additional disclosures or other action is necessary. Recommendations will then be made to the Executive Director as to the appropriate course of conduct both for Head Injury Association and for the personnel involved. Once a final decision is made on how to proceed, the personnel will be instructed as to the course of conduct decided upon.

Confidential Information

Confidential information acquired by personnel about the business of Head Injury Association must be held in confidence and may not be used as a basis for personal gain by the personnel, their families, or others. Information relating to the operations of Head Injury Association's trade secrets, any payroll or other personnel information, and transactions pending with Head Injury Association are not to be released to any person unless this information has been published or otherwise made generally available to the public. Similarly, if Head Injury Association is considering buying, leasing, or selling any property, item, or interest, Head Injury Association personnel and affiliates must not attempt to buy, lease, or sell for their own benefit or that of their family the item under consideration, until after Head Injury Association's decision on the matter has been fully executed. Finally, other than in connection with the personnel's discharge of their official responsibilities with Head Injury Association, all personnel must also refrain from disclosing information about any Head Injury Association consideration or decision, or any other information which might be prejudicial to the interest of Head Injury Association. In addition, Head Injury Association personnel should not disclose or release any medical or Human Resources records without the prior authorization of the appropriate supervisor, and that authorization may only be given in conformity with the rules and regulations governing the confidentiality of those records. The governing principle is that if any material confidential information pertaining to Head Injury Association is received by personnel, they must not use such information for their own or their family's benefit, nor should they disclose it to others.

Protection of Confidential Information

The Head Injury Association has developed policies and procedures to assure that the confidentiality of Head Injury Association information about the individuals we serve is protected and released only with the appropriate authorization or for lawful reasons, in addition to purposes of treatment, payment, and operations. All employees and contractors are required to comply with Head Injury Association's HIPAA policies. If employees/contractors have any questions concerning confidential information or HIPAA policies they are to contact their immediate supervisor or the Compliance Officer.

Governmental Inquiries

Any personnel who receive a governmental request for information, a subpoena, or any other inquiry or legal document regarding Head Injury Association business must promptly notify his or her supervisor before attempting to make a reply. The supervisor should then promptly contact the Compliance Officer, who will notify the Executive Director and legal counsel. If it is appropriate to give a response to a request for information from governmental regulatory agencies, the response given must be accurate and complete. It is Head Injury Association's policy to comply with the law and to cooperate with reasonable demands made during the course of a governmental investigation or inquiry.

Responsibilities of Supervisors and Managers

All Supervisors and Managers have the responsibility to help create and maintain a work environment in which ethical and legal concerns can be raised and openly discussed. They are also responsible to ensure that the personnel they supervise understand the importance of this Code of Conduct and the compliance program; that these personnel are aware of its provisions and of the procedures for reporting suspected unlawful activity; and that all personnel are protected from any type of retaliation if they come forward with information about suspected wrongdoing. All personnel are expected to read and understand this Handbook and to review it as necessary in order to be alert to situations which could create a conflict of interest or otherwise be contrary to the established policies of Head Injury Association. All personnel must, upon receiving a copy of this Handbook, sign and date the Acknowledgment of Receipt attached to the back of this Handbook, and return it to the Human Resources Department.

COMPLIANCE PROCEDURES

To be effective, a Compliance Program must provide for the following: continual reporting of issues or possible violations of the Code of Conduct to the Compliance Officer; enforcement of the Code through the promulgation of disciplinary procedures; continual, periodic reviews and self-audits of our business practices; and implementation of modifications in the compliance program, as necessary, to prevent future violations. Rules and procedures as to each of these topics are set forth below.

The Compliance Officer:

- ☐ Reports directly to Executive Director;
- ☐ Periodically reports directly to the governing body on the activities of the compliance program via the local Compliance Committee;
- ☐ Works with the Board of Directors, Executive Staff, Managers, staff members, legal team, police, regulatory bodies, regulatory and quality auditors;
- ☐ Develops and implements policies and procedures;
- ☐ Develops, oversees and monitors the implementation of the local Quality and Compliance Achievement Plan;
- ☐ Directs internal audits established to monitor effectiveness of compliance standards;
- ☐ Provides guidance to management, medical/clinical personnel, and individual departments regarding policies and governmental laws, rules, and regulations;
- ☐ Investigates compliance-related issues;
- ☐ Implements training;
- ☐ Ensures Corporate Compliance Committee Meetings are held as required and documented.

Pursuant to New York State Social Services Law (SOS) §363-d, providers are required to certify to the Department upon enrollment in the Medicaid program that they are satisfactorily meeting the requirements of SOS §363-d. Furthermore, compliance with the requirements of SOS §363-d is a condition of payment from the Medicaid program. A provider adopting and maintaining an effective compliance program will now record (attest to) this as part of their annual "Certification Statement for Provider Billing Medicaid." This annual certification shall occur on the anniversary date of the provider's enrollment in Medicaid.

Reporting and Complaint Procedures

All personnel should raise any question they might have about potentially unethical or illegal conduct with the Compliance Officer. In this regard, information about suspected illegal conduct must be reported promptly to the Compliance Officer. The intentional or knowing failure to report criminal activity amounts to condoning that activity. As a result, the failure to report knowledge of wrong doing may result in disciplinary action against those who fail to report. Moreover, even if you merely have a general question about the propriety of conduct, you should still reach out to the Compliance Officer for guidance. They are the Compliance Program's "point person," to whom all Officers and personnel can turn to express concerns about such matters. Obviously, it is preferable that questions about a potentially troublesome issue be raised before the issue becomes a legal problem. Should any personnel feel uncomfortable raising an issue with the Compliance Officer, they may contact instead Head Injury Association's Executive Director. Your report or question may be raised anonymously, if you choose, and will be held in the strictest confidence possible, consistent with the need to investigate any allegations of wrongdoing. To the extent possible, the Compliance Officer will not disclose the identity of anyone who reports a suspected violation of law or who participates in an investigation. All personnel should be aware, however, that the Compliance Officer is obligated to act in the best interests of Head Injury Association and does not act as the personal representative for individual personnel. If necessary, the Compliance Officer will work at the direction of outside counsel to conduct the investigation for the purpose of receiving appropriate legal advice for Head Injury Association. Retaliation in any form against an individual who in good faith reports possible unethical or illegal conduct is strictly prohibited and is itself a serious violation of the Code of Conduct. Acts of retaliation should be reported to the Compliance Officer immediately and will be disciplined appropriately. The Compliance Officer will maintain a written record of all reports made of suspected wrongdoing; of all steps taken to investigate those reports; and of all determinations made as a result of any investigation that may be undertaken.

Discipline for Violations of the Code of Conduct

All personnel are expected to adhere to this Code of Conduct. If the Compliance Officer concludes, after an appropriate investigation, that the Code has been violated, then they will recommend appropriate discipline, including discharge. Such recommendation can be based on the personnel's unlawful or unethical actions, condoning or failing to report unlawful actions by others, retaliation against those who report suspected wrongdoing, or other violation of the Code of Conduct.

Training

The Compliance Officer is responsible for ensuring that this Compliance Handbook is available to all personnel and for maintaining a file containing each person's signed Acknowledgment of Receipt form. All new personnel should also be provided the opportunity to review this Handbook and sign the Acknowledgment of Receipt form. In addition, the Compliance Officer should develop a schedule of occasional training on compliance issues, as necessary. The training for different groups of personnel should focus on the legal requirements most relevant to their particular jobs.

Corporate Compliance training will be given on the following schedule:

☐ Orientation for new employees and new Board of Directors Members;
☐ Annual refresher training for all staff;

- When changes in regulations and policies take place that require updating of employees;
- When necessary to address newly identified vulnerabilities and corrective actions.

Corporate Compliance training will include:

- Overview of Corporate Compliance;
- Corporate Compliance Plan contents;
- Summary of fraud and abuse laws (including False Claims Act and Whistleblower Provisions and Protections);
- Security and confidentiality (HIPAA guidelines);
- How compliance relates to those being trained including department specific risk areas (Board of Directors, Administration, HR, Financial Office, Management, Direct Support Professionals, etc.);
- Policies of non-intimidation and non-retaliation to encourage good faith participation; articulate expectations for reporting issues and sanctions for non-compliance and non-retaliation for good faith participation; and
- Use of the Compliance Hotline to report compliance concerns confidentially and anonymously.

Hiring Practices

Head Injury Association is dedicated to enhancing a work environment that continues to attract and retain an exceptional workforce. Therefore, it is our policy to:

- Hire, promote, and compensate employees based solely on their qualifications, work performance, and potential, without regard to race, color, religion, national origin, age, sex, disability, sexual orientation, or veteran status;
- Maintain a work environment free of harassment of any type, including sexual, racial, ethnic, or religious harassment, as well as workplace violence;
- Incorporate adherence to and enforcement of the Compliance Program as an element of an employee's annual performance appraisal and as a factor when making decisions regarding promotion;
- Provide training and education programs of sufficient quantity and quality so as to enable employees to perform their jobs effectively, including training and education regarding the Compliance Program; and
- Ensure that individuals who are excluded from participation in federal and state health care programs are not hired or retained in positions that require such participation.

Exclusion (Sanction) Screening

All Board of Directors, existing and new employees, Independent Contractors and vendors will be screened to verify that they have not been sanctioned. The databases of the following entities will be screened to determine exclusion.

- NYS Department of Health: http://www.omig.state.ny.us/data/content/view/72/52/
- Federal Office of Inspector General: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp
- General Services Administration (GSA) Excluded Parties List of GSA: www.epls.gov/
- NYS Medicaid Fraud Database: http://www.omig.state.ny.us/data/content/view/71/52/

The Human Resources Department will be responsible for ensuring that screenings are completed prior to hire and monthly thereafter. Documentation of such screening will be available for review in the employee files. The Director of Human Resources is responsible to communicate the results of the screenings to the appropriate staff and report any discrepancies to the Compliance Officer. The Compliance Officer will be responsible for monitoring for compliance.

Verifying Provider Credentials
To verify professional licensure with New York State Office of the Professions:

- http://www.op.nysed.gov/opsearches.htm

To confirm education/experience/licensure:

- http://www.op.nysed.gov/opsearches.htm

To check a college/university's accreditation:

- http://www.op.nysed.gov/opsearches.htm

Risk Assessment
Risk identification is the process through which the agency becomes aware of the risks in the facility that constitute potential loss exposure to the facility. These methods include both prospective and retrospective identification of risk sources.

The Corporate Compliance Committee

The Corporate Compliance Committee works in collaboration with the Compliance Officer to review and revise policies and procedures, investigate/document allegations and implement/review/revise the Head Injury Association's Compliance Work Plan.

The Corporate Compliance Committee includes a diversified membership that includes a cross-section of each department. Members include, but are not limited to, senior level management, representatives from major services, representatives from Human Resources and representative from the Board of Directors. The Board of Director member has been chosen by the Board of Directors to represent the governing body at the local level. It is assumed that their involvement in the review of the Head Injury Association's Compliance Handbook would represent approval of the Board of Directors.

Meetings are held regularly (quarterly or more often if needed). Minutes are recorded and maintained. The minutes are shared with the Head Injury Association's Executive Director for reporting purposes. An annual report is developed and shared with the Head Injury Association Executive Director for reporting to the Board of Directors.

Ongoing Compliance Reviews
To be effective, a compliance program must provide for regular reviews of business and billing practices to ensure continuing compliance with the Code of Conduct and all applicable laws and regulations. These reviews will include, but are not limited to, the following:

- On a periodic basis, as per Head Injury Association *Quality Improvement Plan*, the Compliance Officer or their designee acting under their supervision, will conduct reviews of service provision and billing practices. These reviews will include a review of the reports of suspected violations of the Code of Conduct to determine if there are any patterns in the violations that might indicate broader compliance issues. The results of these reviews will be shared at Compliance Committee Meetings held no less than Quarterly. A report will be generated and provided to Head Injury Association's leadership and the Board of Directors for review as submitted.

- The Compliance Officer will conduct periodic checks of the competitive bidding practices for purchases of goods and services; checks on purchases not otherwise subject to the competitive bidding policies; reviews of the financial books and records; and any other audit or review of other business practices the Compliance Officer may deem to be appropriate.

- Reviews by other KINEXION Personnel, all KINEXION Directors, Managers, or other department heads will also periodically review the operations under their supervision to ensure compliance with all applicable laws and regulations.

Overview of Federal and State Laws

In investigating and prosecuting suspected civil and criminal violations in the health care industry, governmental authorities have numerous laws and regulations that they can call upon. There are a wide variety of crimes, both federal and state, that can be committed in the course of a health care provider's business. In addition, there are a number of civil laws, some of which provide for large fines, civil penalties, and damages, which government attorneys can use in combating improper practices. And, finally, there are numerous regulations promulgated by administrative agencies like the Department of Health and Human Services (and its Health Care Financing Administration) pursuant to express statutory authority. These regulations interpret the broad requirements of the federal and state statutes that govern how the health care industry can operate; violation of these regulations can provide the basis for a civil or even criminal prosecution by the state and federal governments. This overview does not cover all potentially applicable civil and criminal laws, and is designed merely as an initial introduction to this sometimes confusing area. Although certain transactions are obviously illegal -- such as the passing of a bag of money to a government official -- many of the transactions prohibited by the fraud and abuse laws are not so obvious. Nevertheless, these laws often carry significant civil and criminal penalties -- such as double or triple damages, heavy fines, as well as the specter of expulsion from the Medicare or Medicaid programs. Thus, this overview is not a substitute for advice of counsel and should be used only as an initial reference source. If you have any specific questions about application of the laws or regulations discussed, however, please contact the Compliance Officer, who will contact counsel, as necessary.

Laws Relating to Business Activities

Although many health care providers think only of administrative regulations and possible civil penalties when they think of compliance, state and federal investigators also have an arsenal of criminal and related laws which can be used against providers for improper business activities or false billing. Violation of these laws can result in liability for both the individual and the institution, large penalties being assessed against both, possible exclusion from the Medicare and Medicaid programs, and even imprisonment for the individual. A familiarity with these laws is thus necessary.

False Claims and Fraud Prosecutions

Both federal and state laws can be applied to false claims and allegedly fraudulent conduct and can result in either civil or criminal prosecutions. The Federal Laws.

- ***The False Claims Act:*** In prosecuting false claims violations, the weapon of choice for federal prosecutors has become the Federal False Claims Act. 31 U.S.C. §§ 3729 et. seq. The Act provides for a minimum $5,000 penalty -- and as much as a $10,000 penalty -- for each false claim for payment that is submitted to the federal government. In addition, the government can also collect double or triple damages; that is, double or triple the amount of the overpayments. Moreover, the government need prove only that the defendant acted "knowingly" in submitting the claims. This means that the government need prove only that the defendant (i) submitted the claims with actual knowledge that they were false or (ii) submitted them with a deliberate ignorance as to their truth or falsity or (iii) submitted them with a reckless disregard for their truth or falsity. Importantly, no specific intent to defraud is required.
- ***Health Care Fraud:*** The Health Insurance Portability and Accountability Act of 1996 created several new health care fraud federal crimes. Under the provisions of the Act, it is now a separate, federal crime to do any of the following:

- It is a crime to knowingly and willfully execute, or attempt to execute, a scheme either to defraud a health care benefits program or to obtain, by means of false representations or pretenses, any money or property owned or controlled by a health care benefits program (penalties include fines and ten years in prison; twenty years in prison if the violations results in serious bodily injury; and life imprisonment if the violations results in someone's death).
- It is also a crime to knowingly and willfully steal or embezzle money from a health care benefits program (penalties include fines and up to ten years in prison).
- It is also a crime to knowingly and willfully make false or fraudulent statements or representations in connection with a health care benefits program (penalties include fines and up to five years in prison).
- It is a crime to willfully obstruct a criminal investigation relating to a violation of a federal health care offense (penalties include fines and up to five years in prison).

A "health care benefits program" is defined as "any public or private plan or contract, affecting commerce under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity providing such medical benefit, item or service for which payment may be made under the plan or contract."

- Federal criminal charges, under the mail and wire fraud statutes, can also be brought against an institution or an individual, if the mail or a wire service is used in conjunction with a scheme to defraud. Under the mail and wire fraud statutes, it is a felony to use the mails, wires, or private courier services to further a scheme to defraud another of money, property, or the intangible right of honest services. 18 U.S.C. §§ 1341, 1343. A person convicted under these statutes faces a possible five-year prison sentence and a fine. Like the federal False Claims Act, the wire and mail fraud laws permit the criminal prosecution of a defendant for each act of wrongdoing. Thus, for instance, if a person knowingly submits documents with false statements in them to a governmental agency -- and submits them via mail, courier, fax, or computer -- each mailing that includes a false statement would constitute a separate crime. It thus does not take long for a pattern or practice to blossom into a multi-count criminal indictment.
- If the third-party payor that is overbilled happens to be Medicare or Medicaid, then additional federal charges can be brought for violating the Medicare and Medicaid False Statement Act. 42 U.S.C. § 1320a-7b. To be guilty of this crime, the person must knowingly and willfully make a false statement as to a material fact in an application for payment, or knowingly conceal a material fact with an intent to fraudulently secure payment. If convicted, a person faces up to five years in prison and a $25,000 fine. See also 18 U.S.C. § 1035 (as recently amended).
- Under certain circumstances, it is crime to conceal or fail to disclose information that you have overbilled Medicare or Medicaid. Specifically, it is felony if a person: (i) has information that he or she knows affects his or her initial or continued right to receive payments under Medicare or Medicaid; (ii) conceals or fails to disclose that information to the government; and (iii) does so with the fraudulent intent to secure a payment that is not authorized in whole or part. If convicted, the person faces up to five years in prison and a $25,000 fine. 18 U.S.C. § 1320a-7b(a)(3). For example, assume that an individual in a residence dies, but the company accidentally continues to count that individual in the census for the residence for a week and receives reimbursement for that individual for that week. Such an innocent error involves no criminal conduct on the part of the company and, beyond the obligation to refund the overpayment to the government (with interest), should expose the company in most cases to no additional liability (assuming, that is, that the error was innocent and was not part of a larger pattern of overbilling). But, if the company discovers the error, and chooses to conceal it and keep the overpayment, then a crime has occurred. Under those circumstances, the company -- and anyone who assists in concealing the error -- is potentially guilty of a felony and subject to imprisonment and a fine.

Exclusion

Federal law also provides that an individual or entity may be excluded from participating in Medicare or Medicaid. 42 U.S.C. § 1320a-7. If the individual or entity is convicted of a "program-related crime" that is related to the delivery of an item or service, then exclusion for a period of at least five years is mandatory. Under the recently enacted Health Insurance Portability and Accountability Act of 1996, exclusion is also mandatory if the conviction is a felony relating to "health care fraud." If the individual or entity, however, is convicted of a lesser federal or state crime relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, then the exclusion is discretionary. Under the new Act, this permissive exclusion will be for three years, unless there is a finding of aggravating or mitigating factors. Whether discretionary exclusion is imposed will depend in part on the federal government's belief that such exclusion is necessary to protect the program from future harm. That belief, obviously, will be heavily influenced by the existence of an effective compliance program that will minimize the chance that the fraudulent behavior will reoccur.

Civil Monetary Penalties

Other federal laws also provide for additional civil penalties. For instance, the Civil Monetary Penalties Act, as amended by the recently enacted Health Insurance Portability and Accountability Act of 1996, provides for a $10,000 civil monetary penalty for each instance of filing either claims for services which the person knew or should have known were not provided or for claims which he or she knew or should have known were false or fraudulent. It also provides for treble damages and possible exclusion. In addition, under the new Act, the definitions of an improperly filed claim now also explicitly list claims for services that the person knows or should have known were not medically necessary. 42 U.S.C. § 1320a-7a. Also, the Program Fraud Civil Remedies Act provides that, in addition to any other remedy prescribed by law, an additional penalty for each false claim can be imposed up to $5,000 dollars. Moreover, under this Act, double damages can also be assessed. 31 U.S.C. § 3801 et. seq.

New York State Laws

There are many crimes under New York State law which a person or organization can commit in the course of delivering or helping to deliver health care services. This section will review only the most obvious and serious of them. Most of the crimes discussed here are felonies: that is, crimes for which a person could serve more than one year in prison. A few of the crimes are misdemeanors: that is, crimes for which a person can spend up to a year in a local jail. These include:

- ***Offering a False Statement for Filing:*** When a person submits a claim for reimbursement for services to New York State, knowing that the claim is false and intending to defraud the state, that person may be guilty of the felony of Offering a False Statement for Filing. New York Penal Law § 175.35."
- ***Insurance Fraud*:** A person commits insurance fraud when he or she submits a fraudulent claim to an insurer for payment. To be guilty of this crime, the person must have submitted the claim with the intent to defraud the insurer and knowing that the claim either contained materially false information or concealed information concerning a material fact. Depending on whether, or how much, money the person obtains from the fraud, he or she will be guilty of a misdemeanor (if nothing is obtained) up to a very serious Class B felony (if more than a million dollars is obtained). See New York Penal Law Article 178. Sentences can range from six months up to 25 years in jail.
- ***Scheme to Defraud:*** If a person engages in a pattern of systematic, ongoing fraudulent activity, then he or she may be guilty of the crime of Scheme to Defraud. To be guilty of this crime, the person must engage in an ongoing course of conduct with the intent to defraud one or more other persons through false pretenses, representations, or promises, and must actually obtain property as a result. New York Penal Law §§ 190.60, 190.65.

- ***Falsifying Business Records:*** If a person tampers with or alters a business record with the intent to defraud, then that person may be guilty of Falsifying Business Records. New York Penal Law §§ 175.05, 175.10.
- ***Issuing a False Financial Statement:*** If a person makes a written financial statement, knowing that it contains a false statement or false information, then that person is guilty of issuing a false financial statement. New York Penal Law § 175.45. Thus, a health care provider might be charged with this crime if it submits a bill to the government or an insurer which is, in whole or part, based on the provider's costs, as opposed to fixed fee schedule, and the provider has knowingly created a false cost report or other financial record.
- ***Theft Prosecutions:*** When submission of false claims result in overpayments to a health care provider, then a separate crime has occurred under state law -- petit or grand larceny. A larceny occurs when a person steals property: when he or she wrongfully takes another's property with the intent to deprive the other of that property. Depending on the amount of money involved, the theft can be charged as either petit or grand larceny. New York Penal Law Article 155. Multiple small thefts against the same victim pursuant to a single intent and in furtherance of a common fraudulent scheme -- such as submission of many false claims to Medicaid -- can be aggregated into a single charge of grand larceny. The New York State Medicaid Fraud Control Unit often uses the State larceny statute in its prosecutions of health care providers who have fraudulently obtained payments from governmental agencies.
- ***Bribery Prosecutions:*** There are a number of different wrongful acts that come under the broad heading of bribery, which is a felony. A person can be guilty not only of bribing a public servant, but also of engaging in commercial bribery. Each form of bribery, moreover, only requires that an "offer" be made to confer a benefit on the bribe receiver; if the bribe is refused, the crime of bribery nonetheless may have taken place. In addition, the bribe receiver will also be guilty of his or her own crime of bribe receiving.
- ***Bribery Involving a Public Servant:*** Bribery of a public servant occurs when a person either gives or offers to give any benefit to a public official or employee upon an agreement or understanding that the public official's conduct will be influenced by receiving the benefit. New York Penal Law Article 200. Assume, for instance, that a house manager offered an OPWDD official tickets to a basketball game -- or anything else of value -- after a routine inspection of a facility uncovered troublesome violations; and assume that, without anything being said, the official failed to write up the violations. Under these facts, both would be guilty of felonies: the house manager of bribery and the official of bribe receiving. The giving of the tickets is a benefit conferred on the OPWDD official, a public servant, with the understanding that the official's judgment or actions will be influenced because of this gift. The benefit does not have to be large (although if it is greater than $10,000 the crime becomes a more serious felony, bribery in the second degree). Nor does there have to be an express agreement that the official will fail to write up the violations in return for the tickets, as long as an "understanding" can be inferred from all the facts.
- ***Giving Unlawful Gratuities:*** Giving a public servant something of value after he or she has already performed their duty is the felony of Giving an Unlawful Gratuity. New York Penal Law § 200.30. In short, it is also a crime to give a gift to a public servant for doing exactly what he or she is legally required to do, even if there is no expected quid pro quo for the gift.
- ***Commercial Bribery:*** A bribe need not be given to a public official to constitute a crime, but may also be given in an effort to obtain special treatment to someone with whom you are doing business. Thus, an attempt to bribe an employee of a private concern to act against his employer's interests constitutes the crime of Commercial Bribery. New York Penal Law Article 180.00. Like bribery of a public servant, this crime involves an effort to get someone to violate a position of trust, by paying him money or giving him another benefit. As with bribery of a public servant, both the bribe giver and the bribe receiver are guilty of crimes. And, as with bribery of a public servant, to convict someone it is enough that the briber offers to pay the

bribe: as long as the briber has the intent (the goal) to influence the bribed person to act in a certain way, it does not matter that this person does not change her behavior after receiving the benefit. For example, assume that an employee of a company that supplies services to the developmentally disabled wants to get a good deal for the company on purchasing furniture for a new facility, and offers to let the salesman take his family to the employee's cabin in the mountains for a week. The salesman then agrees to sell the company furniture, in bulk, at a price 10% lower than his company has ever sold them before. In this hypothetical, the employee of the group home is guilty of commercial bribery, even if the salesman never uses the cabin, because it is clear that the employee intended to get the salesman to change his behavior in response to the offer and to act against the furniture company's interests by selling the furniture at a deep discount. The salesman is also guilty of the crime of Commercial Bribe Receiving. If the cabin is worth more than $1,000 a week and the furniture company lost more than $250 based on this discount, then both are guilty of felonies; otherwise, they are guilty of misdemeanors.

- ***Conspiracy Prosecutions:*** A number of federal and state laws also punish individuals for agreeing with others to engage in criminal activities. The most basic of these laws is that of conspiracy, often called the "darling" of prosecutors. In addition, the federal Racketeering Influenced and Corrupt Organizations Act (RICO) is, in essence, a very sophisticated conspiracy statute aimed at more complex criminal agreements or enterprises and carries more severe penalties.
- ***Conspiracy:*** If a person agrees with another to commit a crime, with the purpose to commit that crime, then the person is guilty of the state or federal crime of conspiracy; depending on the severity of the crime which the conspirators intend to commit, the conspiracy will be either a felony or a misdemeanor under both State and Federal law. New York Penal Law Article 105; 18 U.S.C. § 371. To be prosecuted for conspiracy, it is not necessary that the underlying crime actually be committed; it is enough that the conspirators merely agreed to commit the crime and that one of them did some act to facilitate the conspiracy. Thus, for example, if a house manager and his or her supervisor agree to steal money from the house's petty cash account, and -- in furtherance of this scheme -- one of them collects the appropriate ledgers that will need to be forged, then both could be found guilty of conspiracy, even if no money is actually stolen.
- ***RICO:*** RICO was originally designed as a tool to prosecute organized crime, but has come to have a much broader reach. RICO covers acts affecting interstate commerce which demonstrate a "pattern of racketeering activity," including mail fraud and wire fraud. Thus, if there were an ongoing enterprise to engage in overbilling, the persons involved could be charged with violating RICO. In addition to criminal penalties, the RICO statute has a treble damages provision. 18 U.S.C. §§ 1961 et. seq. c.
- ***Criminal Facilitation:*** Even a person who does not agree to commit the crime with another, or does not even affirmatively want the crime to be committed, may still be guilty of the crime of Criminal Facilitation under state law. To be guilty of this crime, a person must render some assistance to the person who commits the crime, knowing that it is "probable" that he is, in fact, rendering such aid. New York Penal Law Article 115. In other words, this law makes it a crime "to look the other way" when it is obvious that what you are being asked to do is something which will help another person commit a crime.
- ***Criminal Solicitation:*** Under New York law, a person may also be convicted of the crime of Criminal Solicitation if he or she asks another person to commit an act which is a crime. New York Penal Law Article 100.

The Anti-Kickback Statute

The federal anti-kickback statute makes it unlawful to give or receive any remuneration (which is broadly defined to include money, goods, and services) in exchange for a referral or as an inducement to provide health care services paid for by Medicare or Medicaid. Specifically, the statute makes it unlawful to

"knowingly and willfully" solicit or receive "any remuneration" either "in return for referring an individual" for a service or item covered under Medicare or Medicaid, or "in return for purchasing, leasing, ordering, arranging for or recommending" any "item or service" covered under Medicare or Medicaid. It is similarly unlawful to "knowingly and willfully" offer or pay remuneration "to induce" another person either to refer individuals for a Medicare or Medicaid item or service or to purchase a Medicare or Medicaid item or service. 42 U.S.C. § 1320a-7b(b). Even if the referral is also made with a legitimate purpose, the referral may still violate the statute if there is also the additional purpose to pay for referrals or to receive a financial benefit by making a referral. Whether the illicit intent must be the "primary" purpose of the referral, or whether it need merely be one of several existing purposes, has not been definitively resolved by the courts. In addition, the statute defines "remuneration" very broadly to include not only the traditional kickback, but the giving of virtually anything of value, including "any kickback, bribe, or rebate" given "directly or indirectly, overtly or covertly, in cash or in kind." While the statue is designed to limit the evils of over-utilization, it also recognizes that there are many business relationships that are necessary and appropriate to providing quality care to patients. As a result, the statute and regulations promulgated by the Officer of Inspector General of the United States Department of Health and Human Services provide for a number of limited exceptions from the reach of this statute. These exceptions and safe harbors have numerous, fairly complex requirements. Violation of these provisions is a felony punishable by a $25,000 fine and five-year imprisonment. In addition, an individual or entity that violates the statute can be excluded from participating in Medicare or Medicaid. See 42 U.S.C. § 1320a-7(b)(7).

Waiver of Coinsurance

Under the recently enacted Health Insurance Portability and Accountability Act of 1996, the Civil Monetary Penalties Act was amended to make clear that, for Part B billing, it is illegal to offer remuneration -- defined to include a waiver of coinsurance and deductible amounts -- to a patient to induce that patient to order an item or service for which payment may be made under Medicare or Medicaid. The penalties include a $10,000 fine for each item or service, treble damages, and possible exclusion from the Medicare and Medicaid programs. 42 U.S.C. § 1320a-7a (as amended).

New York State's Anti-Kickback Law

In 1992, New York passed an anti-kickback statute. Social Services Law § 366-d. Under this law, any "medical assistance provider" who furnishes services under Medicaid shall not solicit or receive any payment or other consideration for the referral of services for which Medicaid payments are made. Any activity covered by exemptions or safe harbors under the federal anti-referral laws and regulations are specifically exempted from the statute's reach. Violation of the statute is a misdemeanor and subject to possible double damages. If the provider obtains money in excess of $5,000 from a violation of the statute, then he or she is guilty of an E felony.

Laws Relating to Purchasing and Contracting

In obtaining needed supplies and services, the provider can run afoul of a number of state and federal laws, both civil and criminal. Because of the amounts of money expended, the purchasing and contracting areas can be a lightning rod for government attention and investigation. Regulators and prosecutors believe, for instance, that purchasing officers can be co-opted by vendors and that suppliers are in a tempting position to increase profits by charging inflated prices, using creative accounting, or engaging in outright fraud. In addition, because an institutional health care provider is of necessity community based, there is the possibility that the person who makes the decisions to purchase from a particular vendor or contractor may have a conflict of interest (based on family relationships, business connections, or financial investments) which inappropriately predisposes him or her to choose a particular supplier. Further, it is possible that a supplier may offer the purchasing decision-maker an inducement (direct or indirect, blatant or subtle) to select him or her without regard to the costs or quality of the goods or services provided. When a supplier is chosen based on factors other than quality and price, there is obviously a breach of fiduciary duty (a legal term for the loyalty which a business executive, director, and employee owes to the company). This breach,

however, can also potentially lead to prosecutions under the federal anti-kickback statute and for such crimes as bribery and bribe receiving. A health care provider may also violate "false statement" laws, if documents -- including the institutional cost report -- are submitted to the government or an insurer contain false statements designed to hide this misconduct.

The Federal Laws

The False Claims Act, wire fraud and mail fraud statutes, conspiracy, and RICO, and the anti-kickback statute, all of which are discussed above, all have potential application to the purchasing and contracting relationships. To see how all these federal laws can apply in the purchasing area, consider the following hypothetical examples.

1. *Ann, a sales representative for a Durable Medical Equipment company, offers a "gift" -- expensive theater tickets -- to Bob, the head of purchasing at an agency that supplies services to the developmentally disabled, in order to gain the group home's Medicare or Medicaid business, and Bob graciously accepts. The act of offering and accepting this gift violates the anti-kickback law; both Ann and Bob could be charged with committing a felony. In addition, if the mails, courier, fax, or other wire services are involved in the purchasing transaction, Ann and Bob could be charged with mail or wire fraud. Finally, if Ann and Bob have agreed to violate the anti-kickback law, they may be guilty of conspiracy; and, if they engage in a pattern of these forbidden transactions, they may be charged under RICO.*

2. *Suppose that Chris is a senior manager for an agency that provides services to the developmentally disabled, and that David, Chris' brother-in-law, is the head of a construction company, which is seeking to bid the on the agency's plan to build a new residential facility. David, however, "does a favor" for Chris and gives him the use of his house in the Bahamas for a week in February in return for a look at the other bids submitted on the construction project. David submits the lowest bid, and his bid is accepted. In this hypothetical, David and Chris can obviously be charged with violating the laws governing commercial bribery and bribe receiving, because David has offered (and given) something of value (the week in the Bahamas) in return for gaining an advantage in the bidding process. If any of the numbers in the bid are known to be false, and the mail or wire services are used in bidding on or obtaining payment for the construction work, David and Chris have also committed wire or mail fraud. They may also be guilty of conspiracy if they agreed to violate the sealed bidding requirements, and of violating RICO, if they have engaged in a pattern of bid rigging practices in the past.*

The State Laws

In the two examples above, the people involved could also be charged with violating a number of the state laws described above. For instance, commercial bribery laws apply to efforts to convince an employee of a private concern to act against his employer's interests. To convict someone it is enough that the briber offers to pay the bribe: as long as the briber has the intent (the goal) to influence the bribed person to act in a certain way, it does not matter that this person does not change her behavior after receiving the benefit. Thus, in the examples above, Ann and David (the outside vendors) would be guilty of commercial bribing. Bob and Chris (the health care organization insiders) would be guilty of commercial bribe receiving. Conspiracy, as discussed above, requires only that two or more individuals intend to commit a crime, and that they agree to work together to reach that goal. In the examples above, the two inside-outside pairs, Ann and Bob plus Chris and David, have each implicitly agreed to work together to give the outsider a share of the agency's, in exchange for "a little something" for the insider. This is enough to constitute conspiracy. If the two engage in a pattern of such activities, then they may be charged with enterprise corruption as well.

Qui Tam Actions

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act (FCA) contains a "Qui Tam" or whistleblower provision. An individual citizen who has actual knowledge of allegedly false claims can file a lawsuit on behalf of the U.S. government. If the lawsuit is successful, and provided certain legal requirements are met, the whistleblower may receive an

award ranging from 15%-30% of the amount recovered whether through a favorable judgment or settlement.

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

The Compliance Handbook is a starting point for getting questions answered. Each Affiliate also has internal policies and procedures, both department-specific and organization-wide that detail the methods and means by which recipients should conduct their work activities. Staff are expected to be familiar with policies and procedures that apply to their job functions and should consult these policies when questions arise. Staff are also welcomed and encouraged to read the full Compliance Program Manual, which is available through the Compliance Officer or a department head. In addition to written policies and procedures, Management personnel are available for, and are expected to provide, guidance to individuals under their supervision. As such, questions can be directed to an immediate supervisor, or the Compliance Officer.

It is strongly encouraged that all of our employees utilize the above resources to get their questions answered. However, as an additional resource, has instituted a confidential Compliance Hotline, which serves two purposes. It functions as a confidential hotline for employees and others who are required to internally report questionable conduct or activities. It also serves as a resource for individuals to get answers to general questions about the Compliance Program or specific questions about legal or regulatory requirements. Confidential information received via the Helpline will be provided to a third party only in extreme circumstances.

What if I know of or suspect that another employee is violating the Compliance Handbook and I don't report it?
It is the duty of every staff member to report any actual or suspected violations of the Compliance Handbook (or internal policies and procedures, federal and state laws, etc.). If you are aware of actual or suspected misconduct and you fail to report it, you will be subject to disciplinary action, up to and including termination.

Will I be punished for raising a question about the Compliance Handbook or for reporting what I think is inappropriate behavior under the Compliance Program?
No. Retaliation against any employee for reporting something that he or she sincerely believes may be a violation of the Compliance Handbook (or of an internal policy, federal or state law, etc.), or for participating in good faith in an investigation of suspected misconduct, is strictly prohibited. If you ask a good faith question or make a good faith report and thereafter you believe you are being punished or retaliated against in some way, you should immediately report this to the Compliance Officer.

Questions or reports made in good faith are protected activities, even if it turns out that the report of misconduct was mistaken. However, deliberately making a false report is not protected activity and will result in disciplinary action. Also, self-reporting of your own inappropriate conduct will not result in immunity but will be considered a factor in determining the appropriate discipline.

I am uncomfortable with the idea of "squealing" or telling on my co-workers or staff members – why does the Compliance Handbook require that I do this?
Some staff may be reluctant to question or report misconduct, especially when they are not absolutely certain that the conduct is wrong. Head Injury Association does not consider such questioning or reporting "squealing." The simple truth is that the President of the United States has made fraud and abuse within the health care industry a top priority and, as a result, the federal and state government are actively pursuing

enforcement activities against health care facilities. Consequently, co-workers or others who do not conduct themselves appropriately threaten our very existence. Without holding each and every employee responsible for reporting actual or suspected misconduct, the Compliance Assurance Program would likely be ineffective in its goal of detecting and preventing violations of law. At its heart, the reporting requirement is the 'right thing' to do.

I'm a Manager. Are my responsibilities under the Compliance Handbook any different from a person who is not a Manager or Supervisor?

Yes. Managerial personnel are responsible for discussing the Compliance Handbook with their staff, emphasizing the importance of the Compliance Handbook, taking appropriate action to detect and correct any violations of the Compliance Handbook, imposing consistent and appropriate discipline when indicated, and not condoning or ignoring misconduct that comes to their attention. If an individual that you supervise is found to have violated the Compliance Handbook, and it is determined that such misconduct was reasonably foreseeable by you, you too will be subject to disciplinary action, up to and including termination.

ACKNOWLEDGMENT OF RECEIPT

This Overview has been designed to educate you about some of the laws and regulations that govern the health care industry. It has also been designed to raise your consciousness, by demonstrating the complexity of the myriad laws and regulations that can trip up even the most careful health care provider. The consequences of non-compliance can be severe, and that is why KINEXION, in concert with its affiliates, has set up a compliance program, designated a Compliance Officer, and hired compliance counsel.

If this handbook does nothing else, it should motivate you to think seriously about compliance issues and how they impact upon your professional life and practice. Just as important, it should motivate you to contact the Compliance Officer with any questions or concerns you might have.

Directors and Managers

I acknowledge that I have received the Corporate Compliance Handbook and "A Brief Summary" of the "Compliance Program/Code of Conduct" for the KINEXION Program, Inc. ("KINEXION"). I agree to read the Handbook, to conduct myself in conformity with all of its requirements, to adhere to the spirit and letter of the Code of Conduct, and to cooperate with management in carrying out the objectives of the compliance program.

Acknowledged and agreed:

_____
Signature

_____
Print name

_____
Job Title or Description

_____
Date

Head Injury Association Compliance Handbook