OCEAN PARTNERSHIP FOR CHILDREN, INC.

Corporate Compliance Plan

Approved by the QA Corporate Compliance Committee on November 7, 2019
Approved by the Board of Trustees on November 20, 2019

OCEAN PARTNERSHIP FOR CHILDREN, INC.

Corporate Compliance Plan

I. STATEMENT OF POLICY OF ETHICAL PRACTICES

Ocean Partnership for Children, Inc. (herein referred to as "the agency") has a policy of maintaining the highest level of professional and ethical standards in the conduct of its business. The Agency places the highest importance upon its reputation for honesty, integrity and high ethical standards. This Policy Statement is a reaffirmation of the importance of the highest level of ethical conduct and standards.
These standards can only be achieved and sustained through the actions and conduct of all personnel of the Agency. Each and every employee of the Agency, including management and leadership employees, is obligated to conduct himself/herself in a manner to ensure the maintenance of these standards. Such actions and conduct will be important factors in evaluating an employee's judgment and competence, and an important element in the evaluation of an employee for raises and for promotion. Employees who ignore or discharge the principles of this Compliance Plan will be subject to appropriate disciplinary actions. Employees must be cognizant of all applicable federal and state laws and regulations that apply to and impact upon the Agency's documentation, coding, billing and competitive practices, as well as the day to day activities of the Agency and its employees and agents. Where any question or uncertainty regarding these requirements exists, it is incumbent upon, and the obligation of, each employee to seek guidance from a knowledgeable officer of, or attorney for, the Agency.

In particular, and without limitation, this plan prohibits the Agency and each of its employees from directly or indirectly engaging or participating in any of the following:

A. Improper Claims

Presenting or causing to be presented to the United States government or any other health care payer a claim:

1. Item or Service Not Provided as Claimed
   For a medical or other item or service that such person knows or should know[1] was not provided as claimed, including a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that such person knows or should know will result in a greater payment to the claimant than the code such person knows or should know is applicable to the item or service actually provided;

2. False Claim
   For a medical or other item or service and such person knows or should know the claim is false or fraudulent;

3. Excluded Provided
   For a medical or other item or service furnished during a period in which such person knows or should know the claimant was excluded from the program under which the claim was made;

4. Not Medically Necessary
   For a pattern of medical or other items or services that such person knows or should know are not medically necessary.

B. False Statement in Determining Rights to Benefits

Making, using or causing to be made or used any false record, statement or representation of a material fact for use in determining rights to any benefit or payment under any health care program.

C. Conspiracy to Defraud

Conspiring to defraud the United States Government or any other health care payer by getting a false claim allowed or paid.

D. Health Care Fraud/False Statements Relating to Health Care Matters

Executing or attempting to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false, fictitious or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

E. Anti-Referral

Presenting or causing to be presented a claim for reimbursement to any individual, third party payor which were furnished pursuant to a referral by a physician who has a financial relationship with the Agency, such as defined in 42 U.S.C. § 1395nn.

F. Anti-Kickback

Except as otherwise provided in 42 U.S.C. § 1320a-7b (b), knowingly and willfully:

1. Soliciting or receiving any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind either:

    a. 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 the Federal health care program; or

    b. in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program; or

2. Offering or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person either:

    a. to refer any 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; or

    b. to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program.

G. Antitrust

Engaging in any activity, including without limitation being a member of a multi-provider network or other joint venture or affiliation, which is in restraint of trade or which monopolizes, or attempts to monopolize, any part of interstate trade or commerce.

H. Failure to Report Violations to Compliance Officer

Failing to promptly report to the Compliance Officer (as defined below) any instance described in subparagraphs A - I above with respect to the Agency or any of its employees which is known to such person.

II. APPOINTMENT OF COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

The Compliance Officer

A. In an effort to ensure compliance with this Policy, the Board of Trustees is adopting a formal Compliance Program. To oversee and implement this program, the Agency has appointed the Chief Financial Officer as its Compliance Officer working closely with the HIPAA Privacy/Security Officer on aspects of the compliance program. The Agency has chosen its Compliance Officer based on his/her outstanding record of commitment to honesty, integrity and high ethical standards, and on his/her knowledge and understanding of the applicable laws and regulations. The Compliance Officer will provide for education and training programs for employees, respond to inquiries from any employee regarding appropriate billing, documentation, coding and business practices and investigate any allegations of possible impropriety in conjunction with the Compliance Program Committee.

B. Duties and Responsibilities of the Compliance Officer

The duties and responsibilities of the Compliance Committee shall include but not be limited to, the following:

1. Coordinate development and implementation of the corporate compliance program.

2. Provide staff support for the Board of Trustees Corporate Compliance Committee.

3. Develop and maintain Standards of Conduct as well as other related policies, rules, and procedures.

4. Establish employee reporting channels, including, but not limited to, a compliance hotline, which employees may use to report problems and concerns without fear of retaliation.

5. Implement corporate-wide training and communication programs to ensure that all employees and affiliated parties are educated on the Standards of Conduct, the corporate compliance program, and other specific issues deemed necessary.

6. Monitor the corporate-wide compliance plan for periodic updates when needed.

7. Delegate responsibility to conduct appropriate compliance investigations (i.e. legal, human resources, and internal audit) to ensure proper follow-up and resolution.

8. Coordinate and conduct inquiries and/or investigations when deemed necessary.

9. Establish audit controls and measurements to ensure correct processes are established.

10. Maintain a working knowledge of relevant issues, laws, and regulations through periodicals, seminars, training programs, and peer contact.

11. Report quarterly to the appropriate committee on the status of the compliance program.

12. Respond appropriately if a violation is uncovered, including a direct report to the Board of Trustees or external agency if deemed necessary.

C. Compliance Committee

The Compliance Officer may create one or more committees to advise and assist in the implementation of the compliance program. The purpose of providing for such committees is to allow the Agency to benefit from the combined perspectives of individuals with varying responsibilities in the Agency. The Compliance Committee shall consist of the following voting members: (a) the Executive Director; (b) the Compliance Officer; (c) members of the Board of Trustees, one of whom shall be the Board President; and (d) such other agency staff members as determined by the Committee.

D. Reporting

In general, recommendations from the Compliance Officer regarding compliance matters will be directed to the appropriate officer or manager of the Agency. If the Compliance Officer is not satisfied with the action taken in response to its recommendations, he/she will report such concern to the Chief Executive Officer/Executive Director. In no case will the Agency endeavor to conceal Agency or individual wrongdoing.

E. Establishment of a Hotline

The Compliance Officer shall have an “open door” policy with respect to receiving reports of violations, or suspected violations, of the law or of the Policy and with respect to answering employee questions concerning adherence to the law and to the Policy.

In addition, the Agency shall establish a Hotline to the Compliance Officer for such reporting or questions. The telephone number for the Hotline is 855-662-SAFE (7233). Telephone calls to the SAFE Hotline may come from Agency employees, clients of the Agency or others, whether or not affiliated with the Agency. All information reported to the Agency by any employee in accordance with the Compliance Policy shall be kept confidential by the Agency to the extent that confidentiality is possible throughout any resulting investigation; however, there may be a point where an employee’s identity may become known or may have to be revealed in certain instances when governmental authorities become involved. Under no circumstances shall the reporting of any such information or possible impropriety serve as a basis for any retaliatory actions to be taken against any employee, client or other person making the report to the Hotline.

The telephone number for the SAFE Hotline along with a copy of the Compliance Policy, shall be posted in conspicuous locations throughout the Agency.

III. EDUCATIONAL PROGRAM

A. Purpose of Educational Program

The Compliance Program promotes the Agency's policy of adherence to the highest level of professional and ethical standards, as well as all applicable laws and regulations. The Agency will make available appropriate educational and training programs and resources to ensure that all employees are thoroughly familiar with those areas of law that apply to and impact upon the conduct of their respective duties, including, without limitation, the specific areas of documentation, coding, billing and competitive practices of the Agency.

B. Responsibility for Educational Program

The Director of Organizational Development and Technology & the Quality Assurance Manager will work with the Compliance Officer to ensure implementation of the educational program. The program is intended to provide each employee of the Agency with an appropriate level of information and instruction regarding ethical and legal standards, including without limitation, standards for documentation, coding, billing and competitive practices, and with the appropriate procedures to carry out the Policy. Education and training of all employees shall be conducted at orientation and at least annually. The determination of the level of education needed by particular employees or classes of employees will be made by the Compliance Officer. Each educational program presented by the Agency shall allow for a question and answer period at the end of such program.

C. Subject Matter of Educational Program

The educational program shall explain the applicability of all pertinent laws and regulations related to Medicaid compliance, HIPAA compliance and other federal and state requirements and regulations. As additional legal issues and matters are identified by the Compliance Officer and Committee, those areas will be included in the educational program. Each education and/or training program conducted hereunder shall reinforce the fact that strict compliance with the law and with the Agency's Policy is a condition of employment with the Agency.

D. Training Methods

Different training methods may be utilized to communicate information about applicable laws and regulations to Agency employees. The Agency may conduct training sessions regarding compliance which may be mandatory for selected employees. The seminars will be conducted by the Compliance Officer, Director of Organizational Development and Technology, Quality Assurance Manager, or other members of the management team. The Compliance Officer may require that certain employees or representatives of the Agency attend at the Agency's expense, publicly available seminars covering particular areas of law. The Agency's orientation for new employees will include discussions of the Compliance Program and an employee's obligation to maintain the highest level of ethical and legal conduct and standards.

While the Agency will make every effort to provide appropriate compliance information to all employees, and to respond to all inquiries, no educational and training program, however comprehensive, can anticipate every situation that may present compliance issues. Responsibility for compliance with this Compliance Program, INCLUDING THE DUTY TO SEEK GUIDANCE WHEN IN DOUBT, rests with each employee of the Agency.

IV. EMPLOYEE OBLIGATIONS

The Compliance Policy imposes several obligations on Agency employees, all of which will be enforced by the standard disciplinary measures available to the Agency as an employer. Adherence to the Compliance Program will be considered in personnel evaluations.

A. Employee Obligations

1. Reporting Obligation: Employees must immediately report to the Compliance Officer any suspected or actual violations (whether or not based on personal knowledge) of applicable law or regulations by the Agency or any of its employees. Any employee making a report may do so anonymously if he/she so chooses via the "Safe Hotline" number. Once an employee has made a report, the employee has a continuing obligation to update the report as new information comes into his/her possession. All information reported to the Compliance Officer by any employee in accordance with the Compliance Policy shall be kept confidential by the Agency to the extent that confidentiality is possible throughout any resulting investigation; however, there may be a point where an employee's identity may become known or may have to be revealed in certain instances when governmental authorities become involved. Under no circumstances shall the reporting of any such information or possible impropriety serve as a basis for any retaliatory actions to be taken against any employee making the report.

2. Acknowledgment Statement: Each employee must complete and sign annually, an Acknowledgment Statement to the effect that the employee fully understands the Compliance Program, and acknowledges his/her commitment to comply with the Program as an employee of the Agency. Each acknowledgment statement shall form a part of the personnel file of each employee. It shall be the responsibility of each manager to ensure that all employees under his/her supervision who are materially involved in any of the Agency's documentation, coding, billing and competitive practices have executed such an acknowledgment.

B. Agency Assessment of Employee Performance Under Compliance Program

1. Violation of Applicable Law or Regulation: If an employee violates any law or regulation in the course of his/her employment, the employee will be subject to sanctions by the Agency.

2. Other Violation of the Compliance Program. In addition to direct participation in an illegal act, employees will be subject to disciplinary actions by the Agency for failure to adhere to the principles and policies set forth in this Compliance Program. Examples of actions or omissions that will subject an employee to discipline on this basis include, but are not limited to the following:

    1. a breach of the Agency's policy;

    2. failure to report a suspected or actual violation of law or a breach of the Policy;

    3. failure to make, or falsification of, any certification required under the Compliance Program;

    4. lack of attention or diligence on the part of supervisory personnel that directly or indirectly leads to a violation of law; and/or

    5. direct or indirect retaliation against an employee who reports a violation of the Compliance Policy or a breach of the Policy.

3. Possible Sanctions: The possible sanctions include, but are not limited to, termination, suspension, demotion, reprimand, and/or re-training. Employees who engage in intentional or reckless violation of law, regulation or this Compliance Program will be subject to more severe sanctions than accidental transgressors.

C. Employee Evaluation

Employee participation in, and adherence to, the Compliance Program and related activities will be an element of each employee's annual personnel evaluations including, without limitation, annual personnel evaluations of Agency supervisors and managers. As such, it will affect decisions concerning compensation, promotion, and retention.

D. Non-Employment or Retention of Sanctioned Individuals

The Agency shall not knowingly employ any individual, or contract with any person or entity, who has been convicted of a criminal offense related to health care or who is listed by a Federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care program. In addition, until resolution of such criminal charges or proposed debarment or exclusion, any individual who is charged with criminal offenses related to health care or proposed for exclusion or debarment shall be removed from direct responsibility for, or involvement in, documentation, coding, billing or competitive practices. If resolution results in conviction, debarment or exclusion of the individual, the Agency shall terminate its employment of such individual.

V. RESPONSE TO REPORTS OF VIOLATIONS

The Agency, along with its legal counsel where necessary, shall promptly respond to and investigate all allegations of wrongdoing of Agency employees, whether such allegations are received through the Hotline or Administrative Alert. When a report is received via either system, an email notification is automatically generated and sent to various leadership team members including the Executive Director, the Director of Human Resources, the Chief Financial Officer, The Director of Clinical Operations, & the Director of Organizational Development and Technology. If the report alleges wrongdoing involving any of the above mentioned individuals or their direct reports, that individual will not be involved in the investigative process.

A. Investigation

Upon discovery that a material violation of the law or of the Policy has occurred, the Agency shall take immediate action (within 5 business days) to rectify the violation, if possible, and to report the violation to the appropriate regulatory body, if necessary, and to appropriately sanction the culpable employee(s) of the Agency. Promptly after any discovered material violation is addressed, the Agency shall, with the assistance of the Compliance Officer, amend this Policy in any manner that the Agency or the Compliance Officer feels will prevent any similar violation(s) in the future.

If an investigation of an alleged violation is undertaken and the Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, the employee(s) allegedly involved in the misconduct shall, at the discretion of the Compliance Officer, be removed from his/her/their current work activity until the investigation is completed. In addition, the Agency and the Compliance Officer shall take any steps necessary to prevent the destruction of documents or other evidence relevant to the investigation. Once an investigation is completed, if disciplinary action is warranted, it shall be immediate and imposed in accordance with the Agency's written standards of disciplinary action.

B. Assessing Allegations of Non-Compliance

Allegations of non-compliance are necessarily assessed on a case-by-case basis, and the existence or amount of a monetary loss to a health care reimbursement program is not solely determinative of whether the alleged conduct should be further investigated or reported to government authorities. The Compliance Officer, together with the Executive Director, and legal counsel, if retained, should determine the extent to which corrective actions will be initiated with respect to findings of non-compliance, such as a referral to criminal or civil law enforcement authorities, a corrective action plan, a report to the government, or submission of an overpayment to the appropriate third party payor. If the offense occurred despite the existence of this Compliance Plan, the Compliance Officer will promptly assess whether any change to this Compliance Plan is necessary to prevent similar offenses.

C. Documentation of Investigation

Any investigation initiated as a result of a statement, complaint, suggestion or internal or external auditing process should, (a) describe the alleged violation; (b) describe the investigative process; (c) include copies of interview notes, key documents, a log of the witnesses interviewed and the documents reviewed; and (d) summarize the results of the investigation, any disciplinary action taken and any corrective action implemented. Such documentation should be retained in a central file for compliance matters, and access to such documentation should be limited so as to maintain the confidentiality of the information gathered.

D. Reporting Violations

If the Compliance Officer or Compliance Committee discovers credible evidence of misconduct from any source and, after a reasonable inquiry by the Agency's legal counsel, has reason to believe that the misconduct may violate criminal, civil or administrative law, the Agency, through the Executive Director, shall report the existence of such misconduct to the appropriate government authority. The Agency shall endeavor to make its report within a reasonable period after confirming the existence of such misconduct, with the understanding that such reports should be made no later than sixty (60) days after such a confirmation. Any report of misconduct to the government should be made in accordance with an established policy of the Agency, which policy is consistent with the Agency's legal obligations and interests.

VI. AUDITING AND MONITORING

A. Importance of Auditing and Monitoring

It is critical to the Agency's compliance with the Policy for the Agency to conduct regular auditing and monitoring of the activities of the Agency and its employees in order to identify and to promptly rectify any potential barriers to such compliance.

B. Regular Audits

Regular, periodic audits are conducted as prescribed by the Compliance Officer. Such audits shall evaluate the Agency's compliance with its Compliance Policy and determine what, if any, compliance issues exist. Such audits shall be designed and implemented to ensure compliance with the Agency's Compliance Policy and all applicable federal and state laws.

Compliance audits shall be conducted in accordance with the comprehensive audit procedures established by the Compliance Officer and shall include, at a minimum:

1. Interviews with personnel involved in management, operations and other related activities;

2. Reviews, at least annually, of whether the Compliance Program's elements have been satisfied.

3. Periodic reviews of Agency records with special attention given to procedures relating to documentation, coding, billing, the giving and receiving of remuneration to induce referrals and engagement in certain business affiliations or pricing arrangements that may affect competition; and

4. Reviews of written materials and documentation used by the Agency.

All compliance audit procedures shall be conducted and the investigations and the results thereof, are confidential.

C. Formal Audit Reports

Formal audit reports shall be prepared and submitted by the Compliance Officer to the Corporate Compliance/Quality Assurance Committee and the Board of Trustees to ensure that management is aware of the results and can take whatever steps necessary to correct past problems and deter them from recurring. The audit or other analytical reports shall specifically identify areas where corrective actions are needed and should identify in which cases, if any, subsequent audits or studies would be advisable to ensure that the recommended corrective actions have been implemented and are successful.

The audits will include financial and billing areas as well as medical necessity and evidenced based intervention substantiation. The audits will be conducted on a regular basis in accordance with the schedule established in the annual report and the findings will be documented on the Corporate Compliance Scorecard.

D. Compliance with Applicable Fraud Alerts

The Compliance Officer shall regularly and periodically monitor the issuance of fraud alerts by the Office of the Inspector General of the Department of Health and Human Services. Any and all fraud alerts so issued shall be carefully considered by the Compliance Officer. The Agency shall revise and amend this Compliance Policy, as necessary, in accordance with such fraud alerts. In addition, the Agency shall immediately cease and correct any conduct applicable to the Agency and criticized in any such a fraud alert.

E. Retention of Records and Reports

The Agency shall document its efforts to comply with applicable statutes, regulations and federal health care program requirements. All records and reports created in conjunction with the Agency's adherence to the Compliance Policy are confidential and shall be maintained by the Agency through the administrative alert log or the Safe Hotline database, depending on how the report was made.

HIPAA and HITECH ACT NOTIFICATIONS

Purpose:

To provide guidance for breach notification by covered entities when unpermitted or un-authorized access, acquisition, use and/or disclosure of Ocean Partnership for Children's child and family protected health information occurs. Breach notification will be carried out in compliance with the American Recovery and Reinvestment Act (ARRA)/Health Information Technology for Economic and Clinical Health Act (HITECH) as well as any other federal or state notification law.

Background:

The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law on February 17, 2009. Title XIII of ARRA is the Health Information Technology for Economic and Clinical Health Act (HITECH). HITECH significantly impacts the Health Insurance Portability and Accountability (HIPAA) Privacy and Security Rules. While HIPAA did not require notification when patient protected health information (PHI) was inappropriately disclosed, covered entities may have chosen to include notification as part of the mitigation process. HITECH does require notification of certain breaches of unsecured PHI.

Access: Means the ability or the means necessary to read, write, modify, or communicate data/ information or otherwise use any system resource.

Breach: Means the acquisition, access, use, or disclosure of protected health information (PHI) in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI. For purpose of this definition, "compromises the security or privacy of the PHI" means poses a significant risk of financial, reputational, or other harm to the individual.

Protected Health Information (PHI): Protected health information means individually identifiable health information that is: transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.

Discovery of Breach: A breach of PHI shall be treated as "discovered" as of the first day on which such breach is known to Ocean Partnership for Children or, by exercising reasonable diligence would have been known to Ocean Partnership for Children (includes breaches by the agency's business associates). Ocean Partnership for Children shall be deemed to have knowledge of a breach if such breach is known or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent (business associate) of the agency. Following the discovery of a potential breach, the agency shall begin an investigation, conduct a risk assessment and based on the results of the risk assessment, begin the process to notify each individual whose PHI has been, or is reasonably believed to by the agency to have been, accessed, acquired, used, or disclosed as a result of the breach. Ocean Partnership for Children shall also begin the process of determining what external notifications are required or should be made, and make such notifications in a timely manner.

Breach Investigation Internal Notification Process: The investigation will include completion of a risk assessment, coordinate with others in the agency as appropriate and communicate to committees within the reporting structure as appropriate.

1. Risk Assessment: To determine if an impermissible use or disclosure of PHI constitutes a breach and requires further notification to individuals, media, or the HHS secretary under breach notification requirements, Ocean Partnership for Children will perform a risk assessment to determine if there is significant risk of harm to the individual as a result of the impermissible use or disclosure and will

document the risk assessment. The agency shall document the risk assessment as part of the investigation in the incident report form noting the outcome of the risk assessment process. The risk assessment and the supporting documentation shall be fact specific and address:

A. Consideration of who impermissibly used or to whom the information was impermissibly disclosed.
B. The type and amount of PHI involved.
C. The potential for significant risk of financial, reputational, or other harm.

Note: For an acquisition, access, use or disclosure of PHI to constitute a breach, it must constitute a violation of the Privacy Rule. A use or disclosure of PHI that is incident to an otherwise permissible use or disclosure and occurs despite reasonable safeguards and proper minimum necessary procedures would not be a violation of the Privacy Rule and would not qualify as a potential breach.

2. Maintenance of Breach Information/Log: In addition to following protocols pursuant to the Ocean Partnership for Children incident reporting process, the following protocol will be added:

   A. A description of what happened, including the date of the breach, the date of the discovery of the breach, and the number of clients/patients/students affected, if known will be recorded/collected or logged.
   B. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, etc.)
   C. A description of the action taken with regard to notification of affected parties.
   D. Resolution steps taken to mitigate the breach performance improvement activities for the prevention of future occurrences.

3. Business Associate Responsibilities: The business associate (BA) of the agency that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, without unreasonable delay notify Ocean Partnership for Children of such breach. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the BA to have been, accessed, acquired, or disclosed during such breach. The BA shall provide the agency with any other available information that the agency is required to include in notification to the individual at the time of the notification or promptly thereafter as information becomes available.

4. Workforce Training: Ocean Partnership for Children maintains an active orientation and training program for all staff on the policies and procedures with respect to PHI as necessary and appropriate for the staff to carry out their job responsibilities. Staff are also trained as to how to identify and report breaches within the agency, are notified of their non-retaliation protection rights subsequent to reporting and are notified that failure to comply with policy herein may result in disciplinary action.

FEDERAL DEFICIT REDUCTION ACT POLICY

A. Introduction.

Ocean Partnership for Children, Inc. (referred to herein as the "Agency") has instituted this Federal Deficit Reduction Act Policy as part of its Corporate Compliance Plan ("Compliance Plan").

B. Applicability.

This Policy applies to the Agency's Staff Members, including the Agency's leadership, supervisors, administrators, office personnel and field staff, as well as all contractors and agents of the Agency involved, directly or indirectly, in the provision or monitoring of, or coding or billing for, health care services billed to or payable by any government or private third party payor. This Policy is part of the Agency's Compliance Plan, and is also hereby incorporated by reference into the Agency's Employee Handbook, as same may exist or be adopted or amended from time to time.

C. Section 6032 of the Deficit Reduction Act of 2005.

Section 6032 of the Deficit Reduction Act of 2005 is a federal law that requires certain health care agencies, including the Agency, to assist in preventing, detecting and addressing fraud, waste and abuse in federal health care programs by taking certain actions, including to have in place a policy to describe provisions of certain federal and state anti-fraud and false claim laws. Those laws are summarized below.

D. Federal and State Anti-Fraud and False Claims Laws.

1. Federal Anti-Fraud And False Claims Laws.

a. The Federal False Claims Act ("FCA"), 31 U.S.C. § 3729 et seq.

The FCA is a law that prohibits a person or entity, such as the Agency and its Staff Members, agents and contractors, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the federal government. The FCA also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid and knowingly or improperly retaining an overpayment. These prohibitions extend to claims submitted to federal and federally-funded health care programs, such as Medicare and Medicaid.

The FCA broadly defines "knowing" and "knowingly." Knowledge will have been proven under the FCA if the person or entity: (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. The law specifically provides that a specific intent to defraud is not required to prove a violation.

A person or entity found guilty of violating this law will be liable for civil money penalties. From time to time, the Department of Justice has adjusted these penalties to reflect the rate of inflation and as such, they vary depending on the date the penalty was assessed or the violation occurred. For violations that occurred on or before November 2, 2015, and for fines assessed on or before August 1, 2016 whose associated violations occurred on or before November 2, 2015, civil money penalties between $5,500 and $11,000 per claim can be assessed, plus three times the amount of damages which the government sustains because of the act of that person or entity. For fines assessed after August 1, 2016 whose associated violations occurred after November 2, 2015, civil money penalties between $10,781 and $21,563 per claim can be assessed, plus three times the amount of damages which the government sustains because of the act of that person or entity. For fines assessed after February 3, 2017 whose associated violations occurred after November 2, 2015, civil money penalties between $10,957 and $21,916 per claim can be assessed, plus three times the amount of damages which the government sustains because of the act of that

person The person or entity may also be liable for the government cost in recovering the penalties and damages.

Under the Affordable Care Act, the law was amended to, among other things, extend liability for "reverse false claims," or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the federal government. Thus, overpayments from federally-funded health care programs not returned within required timeframes may create FCA liability. In addition, violating the FCA can provide the basis to subject a person or entity to exclusion from participation in Medicare, Medicaid and other federal health care programs.

Private persons are permitted to bring civil actions for violations of the FCA on behalf of the United States (also known as "qui tam" actions) and are entitled to receive a percentage of monies collected. Persons bringing these claims (known as "relators" or "whistleblowers") are granted protection under the law. Any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the FCA will be entitled under the law to remedies, including reinstatement with seniority, double pay back, interest, special damages sustained as a result of discriminatory treatment, and attorney fees and costs.

b. The Federal Program Fraud Civil Remedies Act, 31 U.S.C. § 3801 et seq. ("PFCRA").

The PFCRA makes it illegal for a person or entity to make, present or submit (or cause to be made, presented or submitted) a "claim" (i.e., a request, demand or submission) for property, services, or money to an "authority" (i.e., an executive department of the federal government, such as the U.S. Department of Health and Human Services) when the person or entity "knows or has reason to know" that the claim: (i) is false, fictitious or fraudulent, or (ii) includes or is supported by any written statement which asserts a material fact that is false, fictitious or fraudulent, or (iii) includes or is supported by any written statement that omits a material fact, is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact, or (iv) is for the provision of items or services which the person or entity has not provided as claimed.

In addition, it is illegal to make, present or submit (or cause to be made, presented or submitted) a written "statement" (i.e., a representation, certification, affirmation, document, record, or accounting or bookkeeping entry made with respect to a claim or to obtain the approval or payment of a claim) if the person or entity "knows or has reason to know" such statement (i) asserts a material fact that is false, fictitious or fraudulent, or (ii) omits a material fact making the statement false, fictitious or fraudulent because of the omission.

Similar to the FCA, the PFCRA broadly defines the terms "knows or has reason to know" as (i) having actual knowledge that the claim or statement is false, fictitious or fraudulent, (ii) acting in deliberate ignorance of the truth or falsity of the claim or statement, or (iii) acting in reckless disregard of the truth or falsity of the claim or statement. The law specifically provides that a specific intent to defraud is not required to prove that the law has been violated. The PFCRA provides for civil penalties for each false claim paid by the government, and, in certain circumstances, an assessment of twice the amount of each claim.

In addition, if a written statement omits a material fact and is false, fictitious or fraudulent because of the omission and is a statement in which the person or entity has a duty to include such material fact and the statement contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement, the law provides for a money penalty for each such statement.

Violation of the PFCRA may include civil money penalties. From time to time, the Department of Justice has adjusted these penalties to reflect the rate of inflation and as such, they vary depending on the date the penalty was assessed or the violation occurred. For violations that occurred on or before November 2, 2015, and for fines assessed on or before August 1, 2016 whose associated violations occurred on or before November 2, 2015, a civil money penalty of $5,500 per claim can be assessed, plus twice the amount of any wrongfully filed claim. For fines assessed after August 1, 2016 whose associated violations occurred after November 2, 2015, a civil money penalty of $10,781 per claim can be assessed, plus twice the amount of any wrongfully filed claim. For fines assessed after February 3, 2017 whose associated violations occurred after November 2, 2015, a civil money penalty of $10,957 per claim can be assessed, plus twice the amount of any wrongfully filed claim.

2. New Jersey Anti-Fraud and False Claims Laws.

a. The New Jersey False Claims Act, P.L. 2007, Chapter 265, as amended by P.L. 2009, Chapter 265 ("NJFCA").

The NJFCA is a state law that prohibits, among other things, knowingly presenting or causing to be presented to an employee, officer or agent of the State of New Jersey, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval, or knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State. The NJFCA also prohibits conspiring to defraud the State by getting a false or fraudulent claim approved or paid by the State.

The NJFCA defines "knowingly" as having actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, or acting in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required. Acts occurring by innocent mistake or as a result of mere negligence will be a defense to an action under the NJFCA.

A person who has violated the NJFCA will be jointly and severally liable to the State of New Jersey for a civil penalty of not less than and not more than the civil penalty allowed under the federal FCA, for each false or fraudulent claim, plus three times the amount of damages which the State sustains (i.e., treble damages). The court may reduce the treble damages to not less than twice the amount of damages the State sustains if the court finds certain factors are met.

Violations of the NJFCA also give rise to liability under the Medical Assistance and Health Services Act (see below), N.J.S.A. 30:4D-17 et seq. Specifically, any person, firm, corporation, partnership, or other legal entity that violates the provisions of the NJFCA will, in addition to other penalties provided by law, be liable for civil penalties of (i) payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the payment was made to the person, firm, corporation, partnership or other legal entity, for the period from the date upon which the payment was made to the date upon which repayment is made to the State of New Jersey; (ii) payment of an amount not to exceed three-fold the amount of such excess benefits or

payments; and (iii) payment in the sum of not less than and not more than the civil money penalty allowed under the federal FCA for each excessive claim for assistance, benefits or payments.

b. Whistleblower Provisions and Protections under the NJFCA, N.J.S.A. § 2A:32C-10.

A person may bring a civil action for a violation of the NJFCA for the person and for the State of New Jersey. The person must also serve the State Attorney General. If the State Attorney General proceeds with and prevails in an action brought by an individual under the NJFCA, the individual is entitled to at least 15% but not more than 25% of the proceeds recovered under any judgment or any proceeds of any settlement, depending on the extent of the individual's involvement. If the State Attorney General does not proceed with an action, the individual will receive an amount the court decides is reasonable, which will be between 25% and 30% of the proceeds of the action or settlement of a claim.

An employee who is discharged, demoted, suspended, threatened, harassed or any in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the NJFCA, including preliminary investigation, may be entitled to special protection. The protection afforded may include reinstatement with the same seniority status such employee would have had, but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney fees.

c. The New Jersey Insurance Fraud Prevention Act ("NJIFPA"), N.J.S.A. § 17:33A-1 et seq.

The NJIFPA makes it unlawful to (i) present or cause to be presented (including the assisting, conspiring or urging of another to present) any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy knowing the statement contains false or misleading information concerning any fact or thing material to the claim, or (ii) conceal or knowingly fail to disclose the occurrence of an event which effects any person's initial or continued right or entitlement to any insurance benefit or payment or the amount of any benefit or payment to which the person is entitled. A violation of this law can subject a person or entity to civil damages equal to three times the amount of damages, tiered money penalties based upon the number of offenses, and a State surcharge. In addition, the law authorizes the State Attorney General to pursue additional criminal penalties.

d. The Medical Assistance and Health Services Act ("MAHSA"), N.J.S.A. § 30:4D-1 et seq.

Provisions in this comprehensive law allow for the imposition of criminal fines and terms of imprisonment for various violations involving the submission of claims for payment under the Medical Assistance Program. For instance, such criminal penalties may be imposed upon a health care provider who willfully receives Medical Assistance payments to which the provider is either not entitled or that are in a greater amount than that to which the provider is entitled. The law also allows penalties to be imposed upon an individual or entity that (i) knowingly and willfully makes or causes to be made any false statement or false representation of a material fact in any claim form in order to receive payment, (ii) knowingly and willfully makes or causes to be made any written or oral false statement for use in determining such payment, or (iii) conceals or fails to disclose the occurrence of an event which affects the right to receive such a payment. Penalties may also be imposed if false

statements or representations of a material fact are made in connection with the conditions or operations of any institution during an initial or recertification process entitling the facility to payments under the Medical Assistance Program. Under the MAHSA, it is also unlawful for an individual or entity to solicit, offer or receive a kickback, rebate or bribe in connection with the furnishing of items or services for which payment is made or the furnishing of items or services whose cost is or may be reported to obtain benefits or payments under Medical Assistance Program. In addition to criminal fines and jail sentences, violators of this law are also subject to civil penalties, which can include treble damages, interest on the overpayments, and not less than and not more than the civil penalty allowed under the federal FCA for each false claim submitted.

The director of the program may also take certain actions against individuals and entities found to be in violation of this law. Specifically, the director may suspend, debar or disqualify, for good cause, any provider presently participating or who has applied for participation in the program, or may suspend, debar or disqualify, for good cause, any individual or entity who is participating directly or indirectly in the Medicaid program, including their agents, employees or independent contractors.

Additionally, if an individual or entity fails to respond within ten (10) days to any order of the director, or any person designated by the director, requiring payment or re-payment of any amount found to be due under this law, the director may issue certificate to the clerk of the Superior Court of New Jersey stating that the person or entity is indebted to the state for the payment of the outstanding amount.

e. Health Care Claims Fraud, N.J.S.A. § 2C:21-4.2, 4.3 and 2C:51-5.

The crime of Health Care Claims Fraud is committed when a false, fictitious or fraudulent or misleading statement of material fact is knowingly or recklessly submitted (or is attempted to be submitted) or a material fact is omitted from any record, bill, claim or other document in connection with payment or reimbursement for health care services by either a licensed health care practitioner or an unlicensed person. In addition to other criminal penalties allowed by law, the penalty for each violation of this law is a fine of up to five times the monetary amount obtained or sought.

A health care practitioner may also be subject to additional penalties, including but not limited to, suspension or forfeiture of his/her license.

f. False Claim for Payment of a Government Contract.

Another New Jersey law, N.J.S.A. 2C:21-34 et seq., makes it a crime to (i) knowingly submit to the government any claim for payment for performance of a government contract knowing that the claim is false, fictitious or fraudulent, and (ii) knowingly making a material representation that is false in connection with the negotiation, award or performance of a government contract. The criminal penalties for violations of this law vary from a crime in the fourth degree to a crime in the second degree depending on the amount of the claim.

g. Whistleblower Protections.

Under the New Jersey Conscientious Employee Protection Act (CEPA), N.J.S.A. § 34:19-1 et seq., employers are prevented from taking any retaliatory action against an employee who discloses (or threatens to disclose) to a supervisor or to a public body any activity, policy or practice of the employer that the employee reasonably believes is fraudulent or criminal and that may

defraud an individual or governmental entity, among others. In addition, the law protects employees who object or refuse to participate in such activity, policy or practice. Specific protection is also given to licensed or certified health care professionals who object to or refuse to participate in any activity, policy or practice that the employee reasonably believes constitutes improper quality of care.

E. Other Fraud and Abuse Laws.

Other fraud and abuse laws are discussed in **Section IV, Regulated Conduct and Guidelines**, of the Agency's Compliance Plan.

F. Procedures for Detecting Fraud, Waste and Abuse.

All Staff Members must, as a condition of continued employment or engagement by the Agency, strictly adhere to the requirements of all federal and state laws prohibiting fraud, waste, and abuse. Under federal and state laws, all members of the Agency have an affirmative duty to prevent, detect, and report fraudulent behavior. Any Staff Member who knows, has reason to know, or reasonably suspects that wrongdoing, fraud, waste, or abuse regarding a federal or state health care program, including Medicare and Medicaid, has occurred within the Agency must immediately report such wrongdoing to the Compliance Officer, the Executive Director or the Safe Hotline number.

Further, it is a condition of continued employment or engagement by the Agency to adhere strictly to the requirements and procedures set forth in the Agency's Compliance Plan, including the Code of Conduct. Violations of the Compliance Plan, including the Code of Conduct, will subject the violator to sanctions, up to and including termination from employment or engagement.

The Agency, as part of its training with regard to the Agency's Compliance Plan and Code of Conduct, will educate all employees regarding procedures for detecting fraud, waste, and abuse.

Any questions regarding the Agency's Compliance Plan, including the Code of Conduct, should be directed to the Compliance Officer or, in the absence of the Compliance Officer, the Executive Director. Actual or suspected violations of the Code of Conduct or Compliance Plan must be reported to the Compliance Officer in person or by mail, work email or telephone, or by utilizing the Agency's Corporate Compliance Safe Hotline.

G. Non-Retaliation.

The Agency will not retaliate against any Staff Member who reports compliance issues in good faith. This means the Agency will not take any negative or adverse act against such Staff Member. Reporting "in good faith" means that you are telling the truth about an issue as you know it. If you believe retaliatory action has been taken against you for reporting an issue in good faith, please contact the Compliance Officer or the Executive Director.

H. Distribution and Acknowledgement.

The Agency will make this Policy available to all Staff Members, including the Agency's leadership, supervisors, administrators, office personnel and field staff, as well as all contractors and agents of the Agency involved, directly or indirectly, in the provision or monitoring of, or coding or billing for, health care services billed to or payable by any government or private third party payor. When required by the Agency, Staff Members, contractors and agents of the Agency must sign an acknowledgement form acknowledging the receipt of this Policy and the Agency's Compliance Plan, including the Code of Conduct.

I. Annual Certification.

The Agency must certify to the State of New Jersey annually that, among other things, its Corporate Compliance Plan and Employee Handbook incorporate the requirements of Section 6032 of the federal Deficit Reduction Act, as required by law. In certain circumstances, the Agency may be required to submit documentation to support the answers provided in the certification. The Agency also may be subject to onsite reviews conducted by the state or federal government to verify compliance.