mosaic health *Better happens together.*		Policy	CC01-01
		Version	2.0
		Date of Last Revision	July 26, 2022
		Effective Date	August 2, 2022
COMPLIANCE PROGRAM			
Last Edit By:	Kate Weidman, Director of Compliance & Training	Date	July 13, 2023
Last Reviewed By:	Policy Committee	Date	July 24, 2024
Last Approved By:	Board of Directors	Date	September 3, 2024
Review Cycle	Annual; Board of Directors- Annual		
Scope:	Mosaic Health Board Members, Employees and Associates (Contractors, Agents, Consultants, Interns, and Students)		
Regulatory Reference	Social Services Law 363-d; 18 NYCRR Section 521-1		

DEFINITIONS

N/A

POLICY

It is the policy of Mosaic Health to conduct business in compliance with all Federal, State, and local laws and regulations, and payer requirements. Mosaic Health has established a Compliance Program Plan and related Compliance policies and procedures (including the Code of Conduct) to assist in developing a proactive and effective Compliance Program. The Compliance Officer is responsible for the administration and oversight of the Compliance Program.

This policy and Compliance Program Plan will be reviewed annually.

RELATED POLICIES/PROCEDURES

CC01-03: Implementing and Revising Policies and Procedures
CC01-04: Detection of Fraud, Waste and Abuse
CC01-07-02: Compliance Remediation and Corrective Action
CC01-08: Compliance Program Training and Education
CC01-09: Conducting Compliance Audits
CC01-13: Conflict of Interest
CC01-14: Whistleblower
CC01-16: Excluded Individuals and Entities
CC02-07: Code of Conduct

This Policy/Procedure shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Mosaic Health's senior management, Federal and State law and regulations, and applicable accrediting and review organizations.

Implementation Manager: Chief Executive Officer

Responsible Parties: Compliance Officer

09-13-2024

Signature
Chief Executive Officer

Date

09-12-2024

Signature
Chair, Board of Directors

Date

VERSION HISTORY				
Version	**Approved By**	**Revision Date**	**Description of Change**	**Author**
1.0	Board of Directors	8/2/22	Initial Policy/Plan	Kate Weidman
2.0	Board of Directors	8/1/23	Addition of Oversight	Kate Weidman

REVIEW HISTORY	
Review Date	**Reviewer**
Board of Directors	2/7/23
Board of Directors	9/3/24

EXHIBITS

Compliance Program Plan

Compliance Program Plan

2024

Approved: September 3, 2024
By: Board of Directors

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I. Compliance Program Scope

The Compliance Program is intended to apply to all of Mosaic Health's activities and to all "affected individuals" which includes Board members, employees, and associates (individuals, contractors (including subcontractors and individual contractors) or agents acting on behalf of Mosaic Health). This Compliance Program Plan is distributed to all individuals newly affiliated with Mosaic Health during orientation and annually thereafter. The Compliance Program Plan is also distributed via the Mosaic Health website.

All Board members, employees, and associates shall acknowledge that it is their responsibility to report any instances of suspected or known non-compliance to their immediate supervisor, the Chief Executive Officer, or the Compliance Officer. Reports may be made anonymously without fear of retaliation, retribution, or intimidation. Failure to report known noncompliance or making reports that are not in good faith will be grounds for disciplinary action, up to and including termination of employment, contract, assignment, or appointment. Reports related to harassment or other workplace-oriented issues will be referred to Human Resources.

II. Compliance Program Plan

Mosaic Health's Compliance Program consists of the following elements:

a. Compliance Program Oversight/Structure

i. The Role of the Compliance Officer

It is the policy of Mosaic Health to have a Compliance Officer to oversee and monitor the adoption, implementation, and maintenance of its Compliance Program and to ensure appropriate handling of instances of suspected or known illegal or unethical conduct. The Compliance Officer's duties include:

- Receiving reports of problems or violations, investigating such reports and coordinating any required corrective action;
- Maintaining a reporting system (confidential and anonymous) and responding to concerns, complaints, and questions related to the Compliance Program;
- Developing and suggesting policies related to compliance to the Board and developing procedures implementing policies approved by the Board;
- Overseeing periodic compliance audits and regular compliance monitoring by department leads;
- Providing guidance to management, clinical program personnel, and individual departments regarding policies and procedures, and governmental laws, rules, and regulations;

- Training and communicating awareness to individuals affiliated with Mosaic Health of the existence and contents of the Compliance Program Plan;
- Reporting incidents of non-compliant conduct to the CEO and Board, as appropriate;
- Ensuring the application of appropriate disciplinary actions or sanctions;
- Updating, periodically (no less than annually), the Compliance Program Plan, as changes to Federal and State laws, rule, regulations, policies and standards occur;
- Evaluating the effectiveness of the Compliance Program; and
- Overseeing and monitoring the implementation of the Compliance Program.

Mosaic Health's Compliance Officer reports to the Chief Executive Officer and is assured direct access to the Board of Directors for the purpose of making reports and recommendations on compliance matters. The Compliance Officer provides regular updates on an as needed basis and a semi-annual report to the full Board of Directors. At least once each year the Compliance Officer's report is made in an executive session between the Board and the Compliance Officer (excluding senior management). The Board Chair may request more frequent reports from the Compliance Officer, as necessary.

ii. The Structure, Duties, and Role of the Compliance Committee(s)

In the Compliance Program, there are two (2) Compliance Committees: Staff level Compliance Committee (Staff Compliance Committee) and Board level (Executive & Compliance Committee).

Mosaic Health's Compliance Officer works closely with department leads/managers and members of the Staff Compliance Committee in implementing the Compliance Program. The Staff Compliance Committee, at a minimum, consists of senior management at Mosaic Health. This includes the Chief Executive Officer, Chief Behavioral Health Officer, Chief Dental Officer, Chief Financial Officer, Chief Medical Officer, Chief Operating Officer, and Compliance Officer. Staff representing various departments and sites are also members of the Staff Compliance Committee. The Compliance Officer serves as the chair of the Staff Compliance Committee. The Staff Compliance Committee meets on a regular basis, but no less frequently than quarterly. The responsibilities of the Staff Compliance Committee are outlined in the Staff Compliance Committee charter (Attachment A).

The Compliance Officer reports every quarter to the Board Executive & Compliance Committee. The Chair of the Executive & Compliance Committee may request more frequent reports from the Compliance Officer, as necessary. The Board Executive & Compliance Committee is responsible for providing direction and guidance to the Compliance Officer about Mosaic Health's compliance with applicable legal requirements using sound ethical principles.

b. Written Standards of Conduct and Policies and Procedures for Promoting Compliance

It is Mosaic Health's policy to address identified areas of risk and to promote compliance by developing written policies and procedures that establish guiding principles or courses of action for affected personnel. These compliance standards, policies, and procedures assist individuals in recognizing compliance issues and to guide them to do the right thing.

Mosaic Health develops and/or revises and implements policies and procedures consistent with the requirements and standards established by the Board of Directors; federal, state, and local laws, rules and regulations; relevant reviewing and accrediting organizations (such as the Bureau of Primary Health Care); and as applicable, commercial health plans.

The Compliance Officer reviews all organizational policies and procedures. Additionally, each policy and procedure are assigned to a department and/or clinical area that is required to review/revise all appropriate policies/procedures annually. To ensure appropriate updates, the Chief Officer may utilize staff workgroups to ensure the policy/procedure is accurate and contains adequate details/information. Once these are reviewed/revised, they are brought to the Policy Committee and/or Chief Officer responsible for the policy/procedure for final approval. Pertinent Compliance procedures and those required to be via compliance obligations, are approved by the Board of Directors and noted in the minutes. Each Chief Officer is responsible for the implementation of approved policies and appropriate in-service training.

Copies of all approved policies and procedures are available through the Mosaic Health Intranet or by requesting a copy from the Compliance Officer.

c. Education and Training

Education and training are critical elements of the Compliance Program. Mosaic Health develops and/or offers ongoing and regular educational and training programs so that all individuals are familiar with the Compliance Program, Compliance policies and procedures, as well as the Code of Conduct.

It is Mosaic Health's policy to ensure that affiliated individuals understand the fraud and abuse laws and, if applicable to their position, the coding and billing requirements imposed by Medicare, Medicaid, and other applicable government healthcare programs and commercial health plans.

Mosaic Health communicates this information through its Compliance training program for newly hired individuals and through on-going training for current employees and Board members. Education and training programs remind employees and Board members that failure to comply may result in disciplinary action and/or termination.

Compliance Training Plan

Mosaic Health shall develop and maintain a training plan. The training plan shall, at a minimum, outline the subjects or topics for training and education, the timing and frequency of the training, which affected individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated (Attachment B).

d. Reporting Compliance Issues

Mosaic Health is committed to establishing and maintaining meaningful and open lines of communication between the Compliance Officer, the CEO, and the Board of Directors. Mosaic Health also recognizes the importance and necessity of open lines of communication between affiliated individuals and the Compliance Officer.

Any individual who is aware of or suspects a violation of an applicable law, rule, regulation or Mosaic Health policies and procedures, including the Standards of Conduct, has an affirmative duty to report this information. All reports of alleged, known, or suspected non-compliance may be reported through the regular chain of command. Such reports should be reported to the Compliance Officer by the manger or supervisor. Any individual who, for any reason, is uncomfortable with reporting through the normal chain of command can report the information directly to the Compliance Officer or Board Chair.

Mosaic Health has a formalized system of communication to report potential non-compliance to the Compliance Officer. An individual may communicate information to the Compliance Officer directly by calling the Compliance Hotline at (585) 362-4278 or 205-875-6347.

Mosaic Health takes all necessary steps to maintain the confidentiality of the identity of the individual who has reported the information to the Compliance Officer. However, at some point the identity of such individual may need to be revealed in order to appropriately address the reported matter. Individuals also may make anonymous reports through the hotline, though it is preferred that individuals identify themselves as part of the report.

Failure to report instances of suspected unethical or non-compliant conduct is considered a violation of this Compliance Program Plan and Compliance policies requiring such reporting. In addition, managers and supervisors may be subject to disciplinary action for failing to detect noncompliance with applicable law or policies and procedures where reasonable diligence on the part of the manager or supervisor would have led to the discovery of a problem or violation.

e. Auditing and Monitoring of Compliance Activities

Mosaic Health strives to conduct regular internal monitoring and self-audits of its operations to ascertain problems and weaknesses in its operations and to measure the effectiveness of its

Compliance Program. Ongoing evaluation is critical in detecting non-compliance and will help ensure the success of the Compliance Program.

An ongoing auditing and monitoring system, implemented by the Compliance Officer and in consultation with the Staff Compliance Committee, is an integral component of the auditing and monitoring systems. This ongoing evaluation shall include the following:

- Review of relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions;
- Compliance audits/reviews of policies, standards, and risk areas;
  - Risk Areas include:
    - Billings
    - Payments
    - Ordered Services
    - Medical Necessity
    - Quality of Care
    - Governance
    - Mandatory Reporting
    - Credentialing
    - Contracts, Subcontracts, Agent or Independent Contractor Oversight; and
    - Other risk areas identified by Mosaic Health through organizational experience, Risk Assessment, or audit.
- Review of documentation (medical necessity, quality of care) and billing relating to claims made to federal, state, and private payers for reimbursement, performed internally or by an external consultant as determined by Compliance Officer and Staff Compliance Committee; and
- Conduct inquiries into the background of such applicants, contractors, vendors, and members of the Board of Directors. Including but not limited to:
  - The System for Award Management (SAM)
  - HHS/OIG cumulative sanction report
  - NYS Medicaid Fraud Database
  - Licensure and disciplinary record with NYS Office of Professional Medical Conduct

The audits and reviews will examine Mosaic Health's compliance with specific rules and policies through on-site visits, interviews, and record documentation reviews.

f. Determination & Response to Allegations of Improper and Illegal Activity

Mosaic Health takes appropriate steps to respond to every report of suspected unethical or non-compliant conduct, as well as to address unreported incidents of suspected unethical or non-compliant conduct. These steps may include conducting investigations, reviewing documents, implementing or revising policies and procedures, offering training, conducting audits, and imposing

disciplinary action. As required, Mosaic Health reports violations or misconduct to the government and makes any necessary payments to the government.

The Compliance Officer, Chief Executive Officer, and/or the Staff Compliance Committee shall determine whether there is any basis to suspect that a violation of the Compliance Program Plan has occurred.

If it is determined that a violation *may have* occurred, the matter shall be referred to legal counsel who, with the assistance of the Compliance Officer, shall conduct a more detailed investigation. This investigation may include, but is not limited to, the following:

- Interviews with individuals having knowledge of the facts alleged;
- A review of documents; and
- Legal research and contact with governmental agencies for the purpose of clarification.

If advice is sought from a governmental agency, the request and any written or oral response shall be fully documented. Violations, whether intentional or unintentional, may result in significant civil or criminal sanctions, or both, for institutions and individuals that do not comply with the laws, rules, and regulations.

If Mosaic Health identifies that an overpayment was received from any third-party payer, the appropriate regulatory (funder) and/or prosecutorial (attorney general/police) authority will be appropriately notified with the advice and assistance of counsel. It is Mosaic Health's policy to not retain any funds that are received as a result of overpayments. In instances where it appears that an affirmative fraud may have occurred, appropriate amounts shall be returned after consultation and approval by involved regulatory and/or prosecutorial authorities. Systems shall also be put in place to prevent such overpayments in the future.

Regardless of whether a report is made to a governmental agency, the Compliance Officer shall maintain a record of the investigation, including copies of all pertinent documentation. This record will be considered confidential and privileged and will not be released without the approval of the Chief Executive Officer or legal counsel.

g. Enforcement of Compliance Standards & Disciplinary Standards

Mosaic Health is committed to ensuring that the Compliance Program Plan and related Compliance policies and procedures, including the Standards of Conduct, are adhered to by all individuals affiliated with Mosaic Health through the consistent enforcement of these standards. Enforcement will be accomplished by imposing appropriate disciplinary action. It is Mosaic Health's goal that every individual understands the consequences of improper or non-compliant activities and that all violators will be treated equally.

h. Non-Retaliation, Non-Intimidating, and Whistleblower Provisions and Protections

Mosaic Health will not take any retaliatory action against individuals who, in good faith, report suspected or known misconduct including but not limited to:

- Reporting potential issues;
- Investigating issues;
- Self-evaluations;
- Audits;
- Remedial actions; and
- Reporting to appropriate officials as provided in sections 740 and 741 of the New York State Labor Law.

Anyone who is involved in an act of retaliation, intimidation or harassment of an individual who reports a compliance concern in good faith will be subject to disciplinary action. Affected Individuals who believe they have been subject to retribution, retaliation and/or intimidation for reporting misconduct or good faith participation in the Compliance Program shall report the actions to the Compliance Officer who shall investigate the allegation.

i. Compliance Program Assessment

On an annual basis, Mosaic Health will perform a Compliance Program Assessment. This Assessment will identify areas where compliance activities can improve including but not limited to policies and procedures, training activities, auditing and monitoring activities, and reporting compliance issues.

The Compliance Program Assessment will include on-site visits, interviews with affected individuals, review of records, surveys and other comparable methods the Compliance Officer deems appropriate.

III. Compliance Program Activities and Timeline

Compliance Program Committee Timeline of Activities

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Annual Compliance Report to Board		x										
Compliance Program Plan & Workplan to Board		x										
Executive & Compliance Committee	x			x			x			x		
Executive Session of the Board		x						x				
Compliance Policies to Board			x					x				
Annual Compliance Training- Board and Staff					x							
Compliance Program Assessment Completion									x			
Compliance Risk Assessment Completion									x			
Staff Compliance Committee Meeting	x			x			x			x		
Staff Compliance Committee Charter Review							x					

IV. Overview of Applicable Compliance-Related Laws, Rules and Regulations

Mosaic Health's Compliance Program is a comprehensive organizational program that identifies applicable federal, state and local laws, rules and regulations governing the organization and ensures compliance with these mandates. The following list represents the laws and regulations that Mosaic Health incorporates into its Compliance Program. It is not an exhaustive list of all the requirements with which Mosaic Health will comply, but rather describes those laws most relevant to the following compliance topics: false claims, whistleblower protection, anti-kickback, physician self-referral, and confidentiality. The list will be updated as the laws change, and Mosaic Health's Compliance Officer will update its policies and procedures to reflect these changes.

False Claims

Federal Laws

Civil False Claims Act (31 U.S.C. §§ 3729-3733):
The Federal Civil False Claims Act is a set of federal statutes that, among other things, forbids "knowingly:"

- Presenting or causing the presentation of, a false claim for reimbursement by a federal health care program, including Medicare or Medicaid;
- Making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim;
- Repaying less than what is owed to the government;
- Making, using or causing to be made or used, a false record or statement material to reducing or avoiding repayment to the government;
- Avoiding or decreasing an obligation to pay or transmit money or property to the government; and/or
- Conspiring to defraud the federal government through one of the actions listed above.

To take one of these prohibited actions "knowingly" means to have actual knowledge of the falsity of the information or to act in deliberate ignorance or in reckless disregard of such falsity.

The U.S. Attorney General may bring an action under this law. In addition, the law provides that any "whistleblower" may bring an action under this act on his/her own behalf and for the United States Government.

False Claims Act fines range from $10,781 to $21,563 per false claim, payment of treble damages (i.e., three times the amount of damages sustained by the government due to the violation), and exclusion from participation in federal health care programs such as Medicare or Medicaid.

Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a):
Provides for civil fines for knowingly presenting or causing to be presented to the federal or a state government a claim that the person knows or should know the claim is false or fraudulent.

Penalties include up to triple damages in addition to $5,500-$11,000 per claim or up to $50,000 for a false statement or misrepresentation.

Criminal Penalties Law (42 U.S.C. § 1320a-7b):
Provides for up to 5 years imprisonment and fines up to $25,000 for knowingly and willfully making or causing to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program.

Criminal False Claims Act (18 U.S.C. § 287):
Provides for up to 5 years imprisonment and fines for making or presenting a claim to the federal government, knowing such claim to be false, fictitious, or fraudulent.

Conspiracy to Defraud the Government with Respect to Claims (18 U.S.C. § 286):
Whoever enters into any agreement, combination, conspiracy to defraud the federal government … by obtaining or aiding to obtain the payment or allowance of any false, fictitious or fraudulent claim, is subject to a separate criminal penalty.

Statements or Entries Generally; False Statements Relating to Health Care Matters (18 U.S.C. §§ 1001, 1035):
Provide for criminal liability to anyone who "knowing and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; makes any materially false, fictitious, or fraudulent statement or representation; or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry …"

General Health Care Fraud Statute (18 U.S.C. § 1347):
The Government can prosecute an individual or entity who knowingly and willfully executes or attempts to execute a scheme or artifice to: defraud any health care benefit program, or obtain by means of false 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, in connection with the delivery of or payment for health care benefits, items, or services. Health care benefit program means "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual." Penalties include a fine and/or imprisonment for not more than ten years. If serious bodily injury results, the prison sentence may increase up to 20 years and/or a fine.

Federal Program Fraud Civil Remedies Act (31 U.S.C. §§ 3801-3812):
Provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $10,781 for each false claim or statement, and up to double damages for each false claim for which the government makes a payment.

New York State Laws

State Finance Law Article 13, New York False Claims Act:
The New York False Claims Act imposes penalties and fines on individuals and entities that knowingly file false or fraudulent claims for payment from Medicaid or other State health programs. The potential penalty for knowingly filing a false claim is (1) $6,000 - $12,000 per claim, (2) payment of three times the State's damages, (3) payment of three times the damages sustained by any local government, and (4) payment of the State's legal fees.

The New York False Claims Act allows private individuals to file lawsuits in State court. If the suit eventually concludes with payments back to the State, the person who started the case can recover a percentage of the proceeds based on whether the State did or did not participate in the suit.

Social Services Laws 145-c:
If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement or misrepresenting, concealing or withholding facts (or committing an act intended to mislead, misrepresent, conceal, or withhold facts), then the person's needs shall not be taken in account in determining his or her need or the person's family's need, for six months if a first offense, 12 months if a second offense (or once if benefits received are $1,000 - $3,900), 18 months if a third offense (or once if benefits received are over $3,900) and five years for four or more offenses.

Social Services Law 145-b False Statements:
It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device.

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

Public Health Law § 238-A:
New York State's Stark Law. A practitioner may not make a referral to a health care provider for clinical laboratory services, pharmacy services, radiation therapy services, x-ray or imaging services or physical therapy services if the practitioner or a member of his immediate family has a financial relationship (including an ownership interest, an investment interest or a compensation arrangement) with that provider, unless a statutory or regulatory exception is met.

Public Health Law §§ 17 & 18:
Patients and other qualified persons have a right to access patient information and records maintained by health care facilities licensed by the Department of Health. "Qualified persons"

generally include the patient, legal guardians, executors of an estate, and individuals with a power of attorney. Records must be provided within 10 days of a written request for access and healthcare facilities may charge reasonable fees for copies of said records.

Mental Hygiene Law § 33.13:
Patients or clients have a general right of privacy in their records maintained by the New York State Office of Mental Health and the New York State Office for People with Developmental Disabilities. These records shall not be made public record or released by the Offices unless an exception is met, including, but not limited to, a court order or to mental hygiene legal service or attorneys representing the patient or client in mental hygiene hearings.

Social Services Law 145, Penalties:
Any person who submits false statements or deliberately conceals material information to receive public assistance, including Medicaid, is guilty of a misdemeanor.
Social Services Law 366-b, Penalties for Fraudulent Practices:

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.
b. Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Penal Law Article 155, Larceny:
The crime or larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

a. Fifth degree petit larceny involves property of any amount. It is a Class A misdemeanor.
b. Fourth degree grand larceny involves property valued over $1,000. It is a class E felony.
c. Third degree grand larceny involves property valued over $3,000. It is a class D felony.
d. Second degree grand larceny involves property valued over $50,000. It is a class C felony.
e. First degree grand larceny involves property valued over $1 million. It is a class B felony.

Penal Law Article 175, False Written Statements:
Four crimes in this Article relate to filing false information or claims that have been applied in Medicaid fraud prosecutions.

a. 175.05, Falsifying business records in the second degree involves entering false information, omitting material information, or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.
b. 175.10, Falsifying business records in the first degree includes the elements of the 175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

c. 175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.
d. 175.35, Offering a false instrument for filing in the first degree includes the elements of the second-degree offense and must include intent to defraud the State or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud:
Six crimes in this Article apply to claims for insurance payment, including Medicaid or other health insurance.

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.
c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.
d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.
e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.
f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud:
Five crimes apply to claims for health insurance payment, including Medicaid.

a. Health care fraud in the 5th degree is knowingly filing, with the intent to defraud, a claim for payment for health care items or services that intentionally has false information or omissions. It is a Class A misdemeanor.
b. Health care fraud in the 4th degree is filing false claims for health care items or services and receiving over $3,000 in aggregate within a year from a health plan. It is a Class E felony.
c. Health care fraud in the 3rd degree is filing false claims for health care items or services and receiving over $10,000 in aggregate within a year from a health plan. It is a Class D felony.
d. Health care fraud in the 2nd degree is filing false claims for health care items or services and receiving over $50,000 in aggregate within a year from a health plan. It is a Class C felony.
e. Health care fraud in the 1st degree is filing false claims for health care items or services and receiving over $1 million in aggregate within a year from a health plan. It is a Class B felony.

Whistleblower Protections

The "qui tam" or whistleblower provisions of the False Claims Act allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the United States. Such persons are referred to as "relators."

The whistleblower/relator must file his or her lawsuit on behalf of the government in Federal District Court for a False Claims Act claim. The lawsuit will be filed "under seal," meaning that the lawsuit is kept confidential while the government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

If the government determines that the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the United States Department of Justice under the False Claims Act.

If the government decides not to intervene, the whistleblower/relator can continue with the lawsuit on his or her own. If the lawsuit is successful, and provided certain legal requirements are met, the qui tam relator or whistleblower may receive a percentage of the amount recovered. The whistleblower may also be entitled to reasonable expenses including attorneys' fees and costs for bringing the lawsuit.

The False Claims Act provides that any employee who is subject to retaliation or discrimination by an employer in the terms and conditions of employment because the employee lawfully sought to take action or assist in taking action shall be entitled to all relief necessary to make the employee whole. Whistleblowers may not be discharged, demoted, suspended, threatened, harassed, or discriminated against in the terms and conditions of employment because of lawful actions taken by the employee in connection with an action under the False Claims Act. This includes reinstatement with seniority restored to what it would have been without the retaliation or discrimination, double the amount of back pay, interest on back pay, and compensation for any special damages sustained as a result of the employer's actions, including litigation costs and reasonable attorney's fees.

In addition, under the Pilot Program for Enhancement of Contractor Employee Whistleblower Protections (41 USC § 4712) employees may not be discharged, demoted, or otherwise discriminated against as a reprisal for making a report that s/he reasonably believes is evidence of any of the following:

- Gross mismanagement of a federal grant or contract;
- A gross waste of federal funds;
- An abuse of authority relating to a federal grant or contract;
- A substantial and specific danger to public health or safety; or
- A violation of law, rule, or regulation related to a federal grant or contract (including the competition for, or negotiation of, a grant or contract).

New York State Laws

New York Labor Law 740:
An employer may not take any retaliatory action against an employee (including a former employee or an independent contractor) if the employee objects to, refuses to participate in, or discloses information about an employer's policies, practices or activities that the employee reasonably believes to be (1) in violation of a law or (2) to create a substantial and specific danger to public health or safety. Protected disclosures are those made to a supervisor, regulatory agency, law enforcement agency or a public official (including testimony before a public body conducting an investigation). In limited circumstances, the employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation.

If an employer takes a retaliatory action against the employee, the employee may sue in State court for reinstatement to the same or equivalent position, any lost back wages and benefits and attorneys' fees, a civil penalty of $10,000 on the employer, plus punitive damages if the violation was willful, malicious or wanton.

New York Labor Law 741:
A health care employer may not take any retaliatory action against an employee if the employee objects to, refuses to participate in, or discloses certain information about the employer's policies, practices or activities to a supervisor, regulatory agency, law enforcement agency, public official news media outlet or public social media forum. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care or improper quality of workplace safety. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action.

If an employer takes a retaliatory action against the employee, the employee may sue in State court for reinstatement to the same or equivalent position, any lost back wages and benefits and attorneys' fees, a civil penalty of $10,000 on the employer, plus punitive damages if the violation was willful, malicious or wanton.

Federal False Claims Act (31 U.S.C. 3730(h)) and New York False Claims Act (State Finance Law 191):
An employee who is "discharged, demoted, suspended, threatened, harassed or in any manner discriminated against" because of the employee's lawful acts under the federal or New York False Claims Act is entitled to reinstatement, double back pay with interest, special damages, and litigation costs and attorneys' fees.

Anti-Kickback

Anti-Kickback Statute and Regulations (42 U.S.C. § 1320a-7b(b); 42 C.F.R. § 1001.952): The Anti-Kickback Statue prohibits the knowing and willful solicitation, receipt, offer or payment of "any

remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind" in return for or to induce the referral, arrangement or recommendation of Medicare or Medicaid business. Violation of the Anti-Kickback Statute is a felony and may result in a fine of up to $25,000, imprisonment of up to 5 years, or both. In addition, the Office of the Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") is empowered to suspend or exclude providers or suppliers from participation in the Medicare or Medicaid Programs if it determines, in its discretion, that a provider or supplier has violated the Anti-Kickback Statute.

Arrangements that satisfy all of the requirements of a regulatory "safe harbor" are immune from both criminal prosecution and administrative enforcement by the OIG. Arrangements that do not qualify under a safe harbor are scrutinized under the Anti-Kickback Statute to determine whether, through the particular arrangement, remuneration was given or offered as an inducement for referrals.

New York State Laws

Public Health Law § 238-A:
New York State's Stark Law. A practitioner may not make a referral to a health care provider for clinical laboratory services, pharmacy services, radiation therapy services, x-ray or imaging services or physical therapy services if the practitioner or a member of his immediate family has a financial relationship (including an ownership interest, an investment interest or a compensation arrangement) with that provider, unless a statutory or regulatory exception is met.

Physician Self-Referral

Stark Act (42 U.S.C. § 1395nn): The Stark Act prohibits, with certain statutory exceptions, a physician who has an ownership interest in, or a compensation arrangement with, an entity from referring patients to that entity for the provision of "Designated Health Services" if payment for those services may be made by Medicare or Medicaid.

The Stark Act prohibits physicians from referring a patient for "Designated Health Services" to an entity with which the physician has a financial relationship and for which payment may be made by Medicare or Medicaid. "Designated Health Services" include clinical laboratory services; physical therapy services; occupational therapy services; radiology; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; outpatient prescription drugs; prosthetics, orthotics, and prosthetic devices and supplies; home health services; and inpatient and outpatient hospital services.

Physicians may only own interests in or have relationships with providers or entities that provide Stark services if the relationships or operations are structured to qualify for at least one of the statutory exceptions to the Stark law.

Violations of the Stark Law may result in the denial of payment for the services provided in violation of the prohibition, refunds of amounts collected in violation, a civil penalty of up to $15,000 for each

service arising out of the prohibited referral, exclusion from participation in the federal healthcare programs, and a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law's prohibition.

New York State Laws

Public Health Law § 238-A:
New York State's Stark Law. A practitioner may not make a referral to a health care provider for clinical laboratory services, pharmacy services, radiation therapy services, x-ray or imaging services or physical therapy services if the practitioner or a member of his immediate family has a financial relationship (including an ownership interest, an investment interest or a compensation arrangement) with that provider, unless a statutory or regulatory exception is met.

Confidentiality

Federal Laws

HIPAA Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164): HIPAA established standards and requirements for healthcare providers and health plans to protect confidential patient information. The HIPAA Privacy Rule includes administrative and training requirements; requirements for policies, procedures, and forms regarding how patient information is used and disclosed; requirements regarding patient access to their own information; and agreements and policies regarding how business associates keep information confidential.

The Department of Health and Human Services' Office of Civil Rights enforces the HIPAA privacy regulations. For unintentional violations, penalties are no less than $100 per violation and no more than $50,000 per violation, with an annual cap of $1,500,000 for identical violations. The penalties per violation increase if the violation is due to reasonable cause ($1,000 to $50,000 per violation); willful neglect corrected within 30 days ($10,000 to $50,000 per violation); and willful neglect not corrected within 30 days ($50,000 per violation).

HIPAA Security Rule (45 CFR Part 160 and Subparts A and C of Part 164): The HIPAA Security Rule requires covered entities use appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

New York State Laws

Mental Hygiene Law § 33.13:
Patients or clients have a general right of privacy in their records maintained by the New York State Office of Mental Health and the New York State Office for People with Developmental Disabilities. These records shall not be made public record or released by the Offices unless an exception is met, including, but not limited to, a court order or to mental hygiene legal service or attorneys representing the patient or client in mental hygiene hearings.

Staff Compliance Committee Charter

Purpose

The Staff Compliance Committee advises the Compliance Officer and assists in the development and implementation of Mosaic Health's Compliance Program. Members of the Staff Compliance Committee reflect the various functional components of Mosaic Health, providing necessary subject matter support in identifying and responding to compliance risk areas.

Duties and Responsibilities

As part of their duties, members of the Staff Compliance Committee shall:

- Advise the Compliance Officer and assist in the implementation of the Compliance Program.
- Be charged with the responsibility to protect the confidentiality of the committee, organization, and patient information.
- Analyze and as needed, develop new methods for promoting compliance and identifying potential violations and for soliciting, evaluating, and responding to complaints and reports of alleged non-compliance.

As directed by the Compliance Officer, and with due consideration for their other job responsibilities, the Staff Compliance Committee's functions include:

- **Annual Compliance Work Plan**. The Staff Compliance Committee will assist the Compliance Officer in developing, implementing, enacting modifications, and the overseeing of the annual Compliance Work Plan. The Staff Committee will ensure that the Compliance Officer is allocated sufficient funding, resources and staff to fully perform their responsibilities set forth in the Compliance Work Plan.
- **Developing Strategy**. The Staff Compliance Committee will analyze and as needed, develop new methods for promoting compliance and identifying potential violations and for soliciting, evaluating, and responding to complaints and reports of alleged non-compliance.
- **Identifying Areas of Risk**. The Staff Compliance Committee will assist the Compliance Officer in assessing Mosaic Health's operations to determine areas of risk and, as necessary, will identify measures to address such areas of risk through the Compliance Risk Assessment. In addition, the Staff Compliance Committee will analyze issues affecting health centers (and the health care industry) generally and the legal requirements with which Mosaic Health must comply.
    - Mandatory areas of risk for review include (as applicable):
        - Billings
        - Payments
        - Ordered Services
        - Medical Necessity

        - Quality of Care
        - Governance
        - Mandatory Reporting
        - Credentialing
        - Contractor Oversight
    - The Staff Compliance Committee will identify and address other risk areas that are identified in the Annual Risk Assessment.
- **Policies and Procedures; Training and Educational Materials**. The Staff Compliance Committee will assist in developing, maintaining, implementing, and disseminating approved policies and procedures that identify and address areas of risk and that promote compliance with Mosaic Health's Compliance Program, all applicable laws (including, as applicable, the laws authorizing and implementing Medicaid, Medicare, and other federal and state health care programs, and the requirements under Section 330 of the Public Health Service Act), and requirements imposed by commercial health plans.
- **Monitoring Audits and Investigations**. The Staff Compliance Committee will monitor the results of internal and external audits and investigations for the purpose of identifying or responding to potential risk areas and will recommend and assist in implementing appropriate corrective and preventive action.
- **Ensuring Communication**. The Staff Compliance committee, in coordination with the Compliance Officer, will ensure communication and cooperation by affected individuals on compliance related issues, internal or external audits, or any other functions/activities in the Compliance Program.

Committee Structure

A. The Staff Compliance Committee shall include representatives from Mosaic Health's major departments, such as Finance (Billing), Clinical (Medical, Dental and Behavioral Health), Human Resources, Health Information Technology and Operations. Permanent members of the Staff Compliance Committee shall include:
    - Chief Executive Officer
    - Chief Behavioral Health Officer
    - Chief Dental Officer
    - Chief Financial Officer
    - Chief Medical Officer
    - Chief Operating Officer
    - Compliance Officer
    - At least two non-managerial staff members

    Other staff members may be invited to attend the Staff Compliance Committee as necessary.

B. The Compliance Officer shall serve as the chair of the Staff Compliance Committee.

C. The Staff Compliance Committee shall hold regular meetings on a quarterly basis at predetermined times and dates. The Staff Compliance Committee may meet more

frequently if requested by the Compliance Officer, CEO, or the Board of Directors. Members of the Compliance Committee are expected to attend all meetings. If a member cannot attend a meeting, the member shall notify the Compliance Officer and may elect to send a representative in their place.

D. Minutes of the Staff Compliance Committee shall reflect the time and date of the meeting, the names of those in attendance, a summary of any presentations or reports presented, and details of all actions taken by the Committee.

MOSAIC HEALTH

COMPLIANCE TRAINING PLAN

Overview

The Compliance Training Program incorporates training courses designed to mitigate areas of risks both identified by staff and regulatory requirements (i.e. Office of Medicaid Inspector General (OMIG), Social Services Law 363-d).

Selection of Training & Target Audience

The selection of trainings for the Compliance Training Plan are based on several factors:

- Required risk areas as identified by regulatory entities
- Risk areas determined by the Staff Compliance Committee
- Areas for improvement identified in the Compliance Program Assessment
- Areas identified by the Board of Directors
- Data and trends identified at various committee and through monitoring/auditing activities
- Additional trainings the Compliance Officer deems necessary

Mosaic Health has identified required courses for all staff and specialized training to mitigate or minimize risk based on responsibilities within the organization.

Required Training for All Staff. All staff are required to complete compliance training upon hire and annually. Content of the training includes:

- Mosaic Health's risk areas and organizational experience
- Mosaic Health's written policies and procedures (and where to find them) including but not limited to:
    - Code of Conduct
    - Conflict of Interest
    - Compliance Program
    - Whistleblower and False Claims Act
    - Detection and Prevention of Fraud, Waste and Abuse
    - Compliance Remediation and Corrective Action
    - Employee Handbook
- the role of the compliance officer and the Compliance Committees (Staff and Board-level Executive & Compliance)
- how affected individuals can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation of affected individuals to report suspected illegal or improper conduct and the procedures for submitting such reports, and the protection from intimidation and retaliation for good faith participation in the compliance program
- disciplinary standards, with an emphasis on those standards related to the required provider's compliance program and prevention of fraud, waste, and abuse

- how the required provider responds to compliance issues and implements corrective action plans
- requirements specific to the medical assistance program and the required provider's category or categories of service
- coding and billing requirements and best practices, if applicable
- claim development and the submission process, if applicable

The Compliance Officer may assign additional mandatory compliance training based on role/responsibility within Mosaic Health.

Timeframe & Delivery Method

This training will be completed (as appropriate) by all new staff members upon hire and annually by current staff members. Additional compliance training may be assigned based on title or role/responsibilities.

Compliance training for new staff members is conducted through Mosaic Health's online Learning Management System (Relias). Annual compliance training is also conducted virtually. If staff members are unable to attend, the training will be recorded and placed in Relias.

Tracking Attendance, Completion and Accountability

a. Tracking Methods.

   - New Staff Members: Attendance and/or completion of training courses will be tracked by supervisors and will be confirmed during the new employees' 90-Day Evaluation that is kept within the individuals Human Resources record.

   - Annual Training(s): Attendance and/or completion of training courses will be tracked using the Relias system. Tracking may also be done in a manner appropriate to the method by which the course was conducted (e.g. sign in/out sheets for in person group courses; certificates of completion for individual online courses).

b. Non-Compliance with Training Requirements. The Compliance Officer will monitor staff compliance with training requirements. If the Compliance Officer determines that a staff member has failed to complete necessary training, the staff member will be given a deadline to schedule/complete the necessary training. Failure to complete the training may result in the staff member's referral to Human Resources for appropriate action.

Evaluation of Effectiveness

Periodically, the Compliance Officer will evaluate the effectiveness of the program to determine areas of improvement. This is accomplished through staff surveys, feedback, and the Compliance Program Assessment.

Signature Certificate

Reference number: CQ7VQ-O8APY-YHJFD-MCI3H

Signer	Timestamp	Signature

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Sent:	04 Sep 2024 00:09:31 UTC
Viewed:	07 Sep 2024 00:26:45 UTC
Signed:	13 Sep 2024 01:48:45 UTC

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Sent:	04 Sep 2024 00:09:31 UTC
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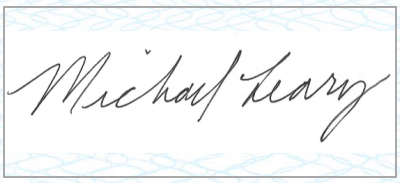

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