COMPLIANCE PROGRAM MANUAL

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INTRODUCTION TO DURAND'S COMPLIANCE PROGRAM

Our Agency has a long-standing commitment to compliance with ethical and legal requirements in our operations and our relationships. In addition, we take seriously our compliance obligations under state and federal law as a contracted provider to the NJ Department of Human Services ("DHS")/Division of Developmental Disabilities ("DDD") and to the NJ Division of Medical Assistance and Health Services (DMAHS or Medicaid). As an approved service provider, our Compliance Program is designed in accordance with the Division's Supports Program and Community Care Program Policy & Procedures Manuals and, specifically, with the following Division Circulars:

> Division Circular #54 – Federal Deficit Reduction Act of 2005, Section 6032 - Policy on Fraud, Waste and Abuse
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> Division Circular #54A – Federal Deficit Reduction Act of 2005, Section 6032 - Policy on Compliance
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> Division Circular #54A, Appendix B, Department of Human Services - Policies and Procedures for Addressing Fraud, Waste and Abuse in Medicaid and Other Health Care Programs for All DDD Providers Participating in the Medicaid Program that are Subject to Section 6032 of the Deficit Reduction Act of 2005
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> Division Circular #40, "Background Checks", establishes guidelines for obtaining criminal history background checks of employees of agencies under contract with DDD. See also DHS Information Bulletin, 06/14/19, *Criminal History Record Information (CHRI) and Hiring*.
>
> See also our policy on *Medicaid Debarment Check – Excluded, Unlicensed or Uncertified Individuals or Entities*, in our Residential and ATS Policy and Procedure Manual

Our Compliance Program is described in the following pages. However, in order to make our Compliance Program more effective and integrated within our overall policies and procedures, additional details of our Compliance Program are set forth in **Durand's Employee Handbook**, where employees attest to adherence to our mission and values (both core and supporting), and in **Durand's Residential and ATS Policy and Procedure Manual**, which is a source for employees on operating procedures set by our Agency and by the Division Circulars and Program Manuals. Our Agency's **HIPAA Privacy Manual**, **HIPAA Security Manual**, and **Business Continuity Plan** further support our Compliance Program.

Policy on Addressing Fraud, Waste and Abuse

Section 6032 of the federal Deficit Reduction Act of 2005 (Public Law 109-171) requires certain providers that receive Medicaid funding, like our Agency, to take actions that will address fraud, waste and abuse in our programs that receive Medicaid. It is our policy to be in compliance with the federal and state laws and regulations related to the Deficit Reduction Act, which are set forth at Exhibit A of this Compliance Program binder and in our Employee Handbook.

The Deficit Reduction Act provides that our Agency do the following:

1. Establish written policies for all employees (including management) and contractors/agents of our Agency that provide detailed information about applicable Federal and State laws on false claims and administrative remedies; fraud, waste and abuse; and whistleblower protections and detailed provisions regarding our policies and procedures for detecting fraud, waste and abuse. In addition, DDD requires that we comply with all applicable DMAHS Newsletters and Alerts relating to fraud, waste and abuse.

2. Include in our Employee Handbook a specific discussion of these laws, the rights of employees to be protected as whistleblowers, and the policies and procedures that our Agency has in place to detect and prevent fraud, waste and abuse in these programs.

3. Require contractors and agents that do business with our Agency to adopt similar policies and make them available to their employees.

4. Post information on how our employees may report Medicaid fraud, waste or abuse.

Related Division Circulars

The reporting required by the following Division Circulars complement, but is not replaced by, our Compliance Program reporting procedure:

Division Circular #14, "Reporting Unusual Incidents", requires reporting of the abuse, neglect or exploitation of individuals, including inappropriate handling of the individual's resources.

Division Circular #15, "Complaint Investigations in Community Programs", establishes policies for conducting civil investigations in response to allegations or suspicions of abuse, neglect, and exploitation. An investigation may center on financial exploitation of the individual.

The Seven Basic Elements of our Compliance Program

Division Circular #54A, Appendix B, states that it is the goal of DHS that all DHS agencies subject to Section 6032 comply with the seven basic elements of the OIG Compliance Program Guidance for Hospitals and the OIG Compliance Program Guidance for Nursing Facilities, published by the US Department of Health & Human Services' Office of Inspector General ("OIG"), to the extent that those guidelines are applicable, relevant and cost-effective for a particular agency in implementing its compliance program. Links to this guidance can be found in Exhibit B.

In line with the OIG Guidance, our Compliance Program has the following seven basic elements:

1. **Implementing Compliance Policies & Procedures, including a Code of Conduct.** We have developed and distributed a written Code of Conduct, as well as written policies and procedures that include a clearly delineated commitment to compliance by our management and employees, such as including adherence to compliance as an element in evaluating managers and employees, and that address specific areas of potential fraud. Employees operate with an eye towards the Core and Supporting Values outlined in our Employee Handbook.

2. **Designating a Compliance Officer and Compliance Committee.** We have designated a high level, independent employee as our Compliance Officer, charged with the responsibility of operating and monitoring our Compliance Program, and have established our **Continuous Quality Improvement & Compliance Committee (CQICC)** to serve as our Compliance Committee, both of which report directly to the Board of Directors.

Our Quality Assurance Specialist & Compliance Officer serves as the **Compliance Officer** for our Compliance Program and is the focal point for our compliance activities. The Compliance Officer has authority to review all documents and other information held by our Agency that are relevant to our compliance activities, including but not limited to: client records, billing records, employee records, contracts, policies and procedures, and compliance reporting.

The Compliance Officer's primary responsibilities include:

a. Overseeing and monitoring the implementation of our Compliance Program;

b. Reporting on a regular basis to the CQICC and CEO, and periodically to the Board of Directors on activities related to our Compliance Program and on establishing methods to improve our Agency's efficiency and quality of services, and to reduce our Agency's vulnerability to fraud, abuse and waste, including reporting on the effectiveness of our Compliance Reporting procedure;

c. Periodically reviewing and recommending revisions to our Compliance Program in light of changes in our services, in Medicaid law, and in DHS/DDD policies and procedures related to compliance;

d. Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the Compliance Program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent Federal and State laws;

e. Ensuring that independent contractors and agents who furnish services to our Agency are aware of the requirements of our Compliance Program with respect to their services;

f. Coordinating personnel issues with our Agency's Human Resources office to ensure that required background checks have been checked with respect to all employees and independent contractors;

g. Assisting our Agency's financial management, QA Coordinator, and other appropriate members of the CQICC in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments, and in developing an Action Plan to address identified compliance risks;

h. Independently investigating matters related to compliance, including the flexibility to design and coordinate internal investigations in coordination with Human Resources (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all Agency components; and

i. Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

Our **Continual Quality Improvement & Compliance Committee (CQICC)** serves as our Compliance Committee and assists in the implementation and periodic review of the Compliance Program. The CQICC consists of the Director of Residential Services, Director of Adult Training Services, Quality Assurance

Coordinator, Quality Assurance Specialist & Compliance Officer, Maintenance Director, Family Support Coordinator, Business Manager, Director of Human Resources, School Principal, Director of Clinical Services, and Executive Director, and oversees all continuous quality improvement and compliance functions. The CQICC meets quarterly and its functions include:

a. Analyzing the reports of the QA Coordinator from quarterly audits, satisfaction surveys, unplanned outcomes and other data sources, including: Licensing Inspection Reports; Plans of Correction and responses to Plans of Correction; Unusual Incident Reports; Key Indicator Reports; Compliance Officer Reports; and reports of all investigations, internal as well as from the Department of Human Services' Office of Investigations or the Department of Children and Families' Institutional Abuse Investigation Unit;

b. Analyzing the Agency's service environment, the legal requirements with which it must comply, and specific risk areas;

c. Assessing existing policies and procedures that address these areas for possible incorporation into the Compliance Program;

d. Working with appropriate Agency components to develop standards of conduct and policies and procedures to promote compliance;

e. Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out our Agency's standards, policies and procedures a part of its daily operations;

f. Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through our fraud reporting mechanisms;

g. Developing a system to solicit, evaluate and respond to complaints; and

h. Dedication to continuous quality improvement of our services.

3. **Conducting Appropriate Training and Education.** We have developed and implemented regular, effective education and training programs for all affected employees, including executives, managers, and our Board of Directors, on the requirements under the Deficit Reduction Act and our overall Compliance Program. We are required to ensure that employees receive information regarding reporting Medicaid fraud, waste and abuse which we do through our Employee Handbook.

   a. New employees receive information and training on our Compliance Program, our Residential and ATS Policies and Procedures Manual, our HIPAA Privacy and Security Policies and Procedures, and our Business Continuity Plan at new staff orientations.

   b. All employees receive such training annually.

   c. Employees involved with compliance activities and risk areas may attend additional relevant training as warranted.

4. **Developing Open Lines of Communication without Retaliation.** We maintain a process to encourage reporting by employees, clients, and family members, of compliance issues or complaints and have adopted a reporting procedure to protect the anonymity of complainants and policies to protect whistleblowers from retaliation. Our Employee Handbook explains in detail our Agency's culture of candid and open communication, as well as our legal obligation to establish a reporting mechanism that makes reporting easy, and anonymous, if desired. Employees who report in good faith will not be subject to intimidation or retaliation.

   Employee satisfaction surveys will be conducted every two years, including whether the Compliance Reporting Procedure is effective and employees are comfortable accessing it.

   Access to Compliance Officer - Each employee is made aware of our Compliance Officer's name and contact information.
   Reporting and Other Forms of Communication - Each employee is made aware of our Compliance Reporting Procedure via our Employee Handbook and posters displayed in employee common areas. A description of our Compliance Reporting Procedure and forms is attached as Exhibit C.

5. **Responding to Compliance Issues and Detected Deficiencies.** To respond to compliance issues, we have developed a system for:

   a. Responding to compliance issues as they are raised;
   b. Receiving reports of, and investigating potential compliance problems;
   c. Responding to compliance problems as identified in the course of internal and external evaluations and audits;
   d. Correcting problems promptly and thoroughly;
   e. Enforcing appropriate disciplinary action;
   f. Implementing procedures and policies as necessary to reduce the potential for recurrence;
   g. Identifying and reporting compliance issues to DHS/DDD, as appropriate; and
   h. Taking corrective action initiatives, which may include refunding overpayments.

   Specifically, reports from our Compliance Program Reporting Procedure will be funneled to the Compliance Officer, who will determine the location of the alleged non-compliance and the nature of the issue. Depending upon the scope of the issue, the Compliance Officer will contact the Director of the location to request additional information and begin an investigation of the facts. Parties to the investigation will be decided on a case-by-case basis, depending upon the nature of the reported non-compliance. Through the investigation, a decision will be made as to whether the report does indicate non-compliance and the need for corrective action whether by discipline, retraining and/or change in policies and procedures.

   Our CQICC also receives, analyzes and responds to reports of the QA Coordinator as set forth in Section 2, above, and as further described in our CQICC Policy.

6. **Conducting Monitoring, Auditing, and Risk Assessment.** We use audits and other ongoing evaluation techniques to monitor compliance, assist in risk assessment, and address identified problem areas.

Areas of internal audit include:

a. Fiscal
b. Operations (Facilities and Transportation)
c. Therap (electronic health record documentation)
d. Human Resources (training and certifications)
e. Quality Assurance (health, safety, unusual incident reporting, investigations)
f. Residential Services
g. Day Services
h. Durand School
i. Community-Based/Individual Support Services (Family Support)
j. Behavior Support Services
k. Marketing

Directors and Department Administrators for all of Durand's operations conduct their own internal audit and monthly monitoring on key factors that will identify risk areas and highlight non-compliance issues. Quarterly audits of the above areas are conducted and provide a Key Indicator Report to our QA Coordinator who includes this data in reports made at the quarterly Compliance and Quality meeting. We use our Key Indicator Report to gather and analyze data, including from the Office of Program Integrity Assessment & Risk Management. This information, which includes Training and Education, Repayments, Excluded Providers, Expired Licenses, Staffing Ratios, Payroll-based Journal, and Investigations by Intake, is analyzed by the CQICC and reported to our Board of Directors.

Risk Assessment. Statistics gathered from our Key Indicator Report will reflect our adherence to compliance standards and overall quality of service delivery and identify which areas of compliance risk require our focused attention, including whether an area is being maintained sufficiently or is in need of improvement. There is a summary and comparison of data in the named areas in order to create a strategic plan for remediation, as needed, as well as for growth and improvement. If needed, we modify our written policies and procedures, our Action Plan, and/or this Compliance Program Manual to take into consideration the regulatory exposure of each function of our Agency, such as:

a. Billing for items or service not actually rendered;
b. Providing unnecessary services;
c. Duplicate billing;
d. False cost reports or financial statements;
e. Financial arrangements between our Agency and third parties that potentially violate the Anti-Kickback Statute or other similar Federal or State statute or regulation; and
f. Additional risk areas as periodically identified.

The DHS Office of Program Integrity and Accountability issues an annual report on our group home and day programs, which also will be used to inform the CQICC.

We are required to have an annual single audit (section P7.06 of the Contract Policy Manual), performed in accordance with federal OMB Circular A-133 and DHS policy by a licensed accounting firm, to ascertain that our financial statements fairly represent the financial position of the organization, including a review of the DDD/DHS final reports of expenditure (ROE) as mandated by section P2.01 of the Contract Policy Manual.

The Department of Human Services (DHS) Office of Auditing (OOA) performs yearly contract audits for select agencies identifying inappropriate contractor expense items.

7. Enforcing Disciplinary Standards. Our disciplinary policies encourage good faith participation in our Compliance Program. Our Employee Handbook provides that an employee who refuses to follow Compliance Program mandates is subject to the progressive disciplinary process defined in the Handbook, as appropriate.

Good faith participation in our Compliance Program is encouraged through different means, including surveying to test an employee's knowledge of our Compliance Program as well as our corporate culture surrounding compliance issues, e.g., what the employee sees on a daily basis. This information guides our Agency on future training and remediation.

Our disciplinary standards are distributed to all employees and are fairly, evenly, and firmly applied, encouraging good faith participation in the compliance process, including policies that articulate expectations for reporting compliance issues and assisting in their resolution, and outline sanctions for such things as:

a. Failing to report suspected compliance programs;
b. Engaging in non-compliant behavior; and
c. Encouraging, directing, facilitating or permitting, either actively or passively, non-compliance behavior.

In addition, as a Medicaid/DDD approved provider, we are required to check that staff hired, Board of Directors, and contracted vendors utilized are not excluded from working with individuals with developmental disabilities or within a Medicaid provider agency. See Exhibit B of this Manual and DDD Community Care Program Policies & Procedures Manual, Section 15.1.2, and Appendix I. New employees are subject to background checks for criminal convictions and disbarment, exclusion or other ineligibility for participation in Federal health care programs and are required by our Employee Handbook to notify HR of any changes in status.

EXHIBIT A

FRAUD, WASTE AND ABUSE LAWS

Purpose

To identify, remediate and prevent circumstances under which fraud, waste, and abuse occur within our Agency by ensuring that our employees know and understand the applicable laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for persons accessing our services through New Jersey Medicaid. Under Section 6032 of the Deficit Reduction Act of 2005, 42 U.S.C. §1396a(a) (68), our Agency and our employees shall adhere to the federal and state laws described below pertaining to civil or criminal penalties for false claims and statements, and to whistleblower protections under such laws.

Policy

Consistent with federal and state law, our Agency strictly prohibits all acts that constitute fraud, waste, and abuse and has established a Compliance Program to make this clear and to provide guidance to our employees. Our Agency and our employees must comply with applicable federal and state statutes (summarized below) in the delivery of our services. We also expect our vendors and contractors to know and comply with these laws. Cases believed to involve fraud, waste, or abuse shall be investigated by the appropriate staff persons within our Agency and reported to DDD and/or Medicaid, as required.

As used in our Compliance Program the following words and terms have the following meaning:

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself, some other person or to our Agency

"Waste" means activities involving payment or the attempt to obtain reimbursement for services where there was no intent to deceive or misrepresent but the outcome of poor or inefficient claim preparation or filing causes unnecessary costs to the Medicaid program. Waste includes any action or inaction that does not rise to the level of fraud or abuse but results in overpayments or misspent funds.

"Abuse" means activities by any person or organization that are inconsistent with sound fiscal, business, or educational practices, which result in unnecessary costs to Medicaid, or that result in our Agency receiving reimbursement for services that are not necessary or that fail to meet professionally recognized standards for our services

"Claim" means a request for payment related to our Agency's services

"Knowing" and "knowingly" mean that a person, with respect to information--

- (i) has actual knowledge of the information;
- (ii) acts in deliberate ignorance of the truth or falsity of the information;
- (iii) acts in reckless disregard of the truth or falsity of the information; or
- (iv) it is practically certain from the conduct of the person that a certain result will occur

1. Federal False Claims Act, 31 U.S.C. 3729-3733

The Act establishes liability when any person or entity improperly receives payment from or avoids payment to the federal government. In summary, the Act prohibits:

a. Knowingly presenting or causing to be presented to the government a false claim for payment;
b. Knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
c. Conspiring to defraud the government by getting a false claim allowed or paid;
d. Falsely certifying the type or amount of property to be used by the government;
e. Certifying receipt of property on a document without completely knowing that the information is true;
f. Knowingly buying government property from an unauthorized officer of the government, and;
g. Knowingly making, using, or causing to be make or used a false record to avoid or decrease an obligation to pay or transmit property to the government.

Any individual or entity engaging in any of the prohibited actions, including the submission of false claims to federally funded health care programs, is liable for a civil penalty which as of January 30, 2023 is between $13,508 and $27,018 per false claim, plus three times the amount of damages sustained by the federal government. The amount of the false claims penalty is adjusted periodically for inflation in accordance with a federal formula. See 28 C.F.R. 85.5 for the current rate.

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 their own behalf and for the United States Government. These actions, which must be filed in U.S. District Court, are known as “qui tam” actions. The Government, after reviewing the complaint and supporting evidence, may decide either to take over the action, or decline to do so, in which case the whistleblower may bring the action. If either the Government or the whistleblower is successful, the whistleblower is entitled to receive a percentage of the recovery. If prosecuted by the federal government, these qui tam actions are generally handled by the various U.S. Attorney’s Offices, or by the U.S. Justice Department.

Whistleblower Protections:

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 under this act “shall be entitled to all relief necessary to make the employee whole.” This includes reinstatement with seniority restored, 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.

2. Federal Program Fraud Civil Remedies Act, 31 U.S.C. 3801-3812

This Act provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. As of January 30, 2023 civil penalties are $13,508 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to

double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula. See 28 C.F.R. 85.5 for the current rate.

3. <u>New Jersey False Claims Act, N.J.S.A. 2A:32C-1 et seq.</u>

The New Jersey False Claims Act (NJFCA) has similar provisions and prohibited acts as the Federal False Claims Act. For example, the Attorney General may bring an action against an individual or entity that makes a false claim. In addition, the NJFCA allows individuals to bring a private action in the name of the State and individuals may be able to collect a portion of the penalty. The NJFCA also includes similar whistleblower protections to those under the Federal False Claims Act. The NJFCA provides that a person will be liable to the State for the same penalties as under the Federal False Claims Act.

4. <u>New Jersey Medical Assistance and Health Services Act</u> – <u>Criminal Penalties, N.J.S.A. 30:4D-17(a)-(d)</u>

This Act provides criminal penalties for individuals and entities engaging in fraud or other criminal violations relating to Title XIX- funded programs. They include:

a. fraudulent receipt of payments or benefits: crime of the third degree punishable by a fine of up to $15,000, imprisonment for up to 5 years, or both;
b. false claims, statements or omissions, or conversion of benefits or payments: crime of the third degree punishable by a fine of up to
$15,000, imprisonment for up to 5 years, or both;
c. kickbacks, rebates and bribes: crime of the third degree punishable by a fine of up to $15,000, imprisonment for up to 5 years, or both; and
d. false statements or representations about conditions or operations of an institution or facility to qualify for payments: crime of the fourth degree punishable by a fine of up to $10,000, or imprisonment for up to 18 months, or both.

Authorized sentencing dispositions may be found at <u>N.J.S.A.</u> 2C:43-2 and 43-6.

Criminal prosecutions are handled by the Medicaid Fraud Control Unit within the Office of Insurance Fraud Prosecutor, in the Office of the Attorney General.

<u>Civil Remedies, N.J.S.A. 30:4D-17(e)-(l); N.J.S.A. 30:4D-17.1.a</u>

In addition to the criminal sanctions discussed above, violations of the New Jersey Medical Assistance and Health Services Act can also result in the following civil sanctions:

a) unintentional violations: recovery of overpayments and interest;
b) intentional violations: recovery of overpayments, interest, up to triple damages, a penalty not to exceed the amount of civil penalty under the Federal False Claims Act, and an additional penalty between $10,000 and $25,000.

Recovery actions are pursued administratively by the Medicaid Fraud Division in the New Jersey Office of

the State Comptroller, and can be obtained against any individual or entity responsible for, in receipt of, or in possession of the incorrect payments.

In addition to recovery actions, violations can result in the exclusion of an individual or entity from participation in all health care programs funded in whole or in part by the Division of Medical Assistance and Health Services. Recovery and exclusion can also be obtained as part of a criminal prosecution by the Medicaid Fraud Control Unit within the Office of the Insurance Fraud Prosecutor, in the Office of the Attorney General.

5. New Jersey Health Care Claims Fraud Act, N.J.S.A. 2C:21-4.2- 4.3; N.J.S.A. 2C:51-5

This Act provides the following criminal penalties for health care claims fraud, including the submission of false claims to programs funded in whole or in part with state funds:

a. A practitioner who knowingly commits health care claims fraud in the course of providing professional services is guilty of a crime of the second degree, and is subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and to permanent forfeiture of their license;

b. A practitioner who recklessly commits health care claims fraud in the course of providing professional services is guilty of a crime of the third degree, and is subject to a fine of up to 5 times the monetary benefits obtained or sought to be obtained and the suspension of their license at least 1 year;

c. A person who is not a practitioner who knowingly commits health care claims fraud is guilty of a crime of the third degree. Such a person is guilty of a crime of the second degree if that person knowingly commits 5 or more acts of health care claims fraud, and the aggregate monetary benefit obtained or sought to be obtained is at least $1,000. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained;

d. A person who is not a practitioner is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, such a person may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained.

6. New Jersey Conscientious Employee Protection Act, N.J.S.A. 34:19-1, et. seq

New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:

a. Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer, or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;

b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer, or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into the quality of patient care; or

c. Provides information involving deception of or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.

d. Provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.

e. Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:

    i. is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;
    ii. is fraudulent or criminal; or
    iii. is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment.

The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided that the situation is emergent in nature.

7. New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1, et seq.

The purpose of this law is to address insurance fraud in New Jersey by facilitating its detection, eliminating its occurrence and requiring restitution. A person or practitioner is in violation of the Act if they:

a. make false statements regarding an insurance claim;
b. conceal or fail to disclose events that affect a person's right to insurance benefits or payments;
c. make false statements on an insurance application in order to obtain a policy;
d. conspire with or urge any person or practitioner to violate the provisions of the Act; or
e. knowingly benefit from the violation of the Act.

The Commissioner of Banking and Insurance may bring civil actions or levy civil administrative penalties for violations of the Act, including:

1. a penalty of not more than $5,000 for the first violation, $10,000 for the second violation, and $15,000 for each subsequent violation;
2. court costs and attorney's fees;
3. restitution to an insurance company or any person suffering loss; and
4. a surcharge of $1,000, or if there is a settlement, a surcharge of 5% of the settlement payment. Surcharges fund fraud prevention programs.

EXHIBIT B

Additional Laws & Compliance Guidance

OIG Compliance Guidance

- The 1998 OIG compliance guidelines for hospitals can be found at: http://www.oig.hhs.gov/authorities/docs/cpghosp.pdf
- The 2005 OIG supplemental compliance guidelines for hospitals can be found at: http://www.oig.hhs.gov/fraud/docs/complianceguidance/012705HospS_upplementalGuidance.pdf
- The 2000 OIG compliance guidelines for nursing facilities can be found at: http://www.oig.hhs.gov/authorities/docs/cpgnf.pdf

Excluded Persons

A Division of Medical Assistance and Health Services (DMAHS or Medicaid) provider cannot seek reimbursement for any services, goods or supplies that are furnished, ordered, directed, managed or prescribed in whole or in part by any individual or entity that has either been excluded from participation in Medicaid and other programs by the OIG or DMAHS, or is unlicensed. DMAHS lists three databases that should be checked to assure that providers do not hire or do business with individuals and entities that have been excluded or have lost their professional licenses. The three databases are:

1. State of New Jersey debarment list (mandatory): **https://nj.gov/comptroller/doc/nj_debarment_list.pdf**

2. Federal exclusions database (mandatory): **https://exclusions.oig.hhs.gov/**

3. N.J. Treasurer's exclusions database (mandatory): **http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml**

4. N.J. Division of Consumer Affairs licensure databases, including all licensed healthcare professionals (mandatory, if applicable): **http://www.njconsumeraffairs.gov/Pages/verification.aspx**

5. N.J. Department of Health licensure and certification database, including: Nursing Home Administrators, Certified Assisted Living Administrators, Certified Nurse Aides/Personal Care Assistants, and Certified Medication Aides (mandatory, if applicable): **https://njna.psiexams.com/.**

6. Federal exclusions and licensure database (optional and fee-based): **https://www.npdb.hrsa.gov/hcorg/pds.jsp**. Please note that only certain provider types may access this database. See **www.npdb.hrsa.gov/hcorg/register.jsp** for more information.

EXHIBIT C

Compliance Program - Procedure for Reports
Regarding Medicaid Fraud, Waste or Abuse

You (the employee) are expected to be familiar with and adhere to our Compliance Program and the federal and state laws governing Medicaid fraud, waste and abuse. These laws are explained in Exhibit A of this Manual and of our Employee Handbook. You play a role in helping us detect any fraud, waste or abuse in our programs. Your knowledge—or reasonable suspicion—of a violation of our Compliance policies and procedures or any of these laws should be promptly reported as described below. Failure to report such a violation may subject you to disciplinary action up to and including, but not limited to, termination.

We are committed to a "speak up" culture when it comes to compliance. You should never hesitate to ask a question or raise a legitimate concern. We also ask that you be open to questions, complaints and concerns raised by our clients, a family member or the people with whom you work, including the people you may supervise.

We provide several channels for employees to ask questions, obtain guidance, and confidentially report compliance concerns. These channels are also available to you for reporting concerns related to health and safety, human resources, and HIPAA. You are encouraged to first talk to your supervisor or another member of our management or human resources team or go directly to our Compliance Officer, Kathleen Breslin [856-840-9569 or k.breslin@durandac.org]. Many questions and issues can be resolved this way. However, if you have a question or concern that you don't feel comfortable discussing with any of these persons, you can report anonymously using our toll-free hotline 844-932-6675, or use our Reporting Form to report issues of non-compliance. You can provide your name or you can report anonymously. However, if you tell others about your report, your anonymity will be affected. The Reporting Form can be placed in locked reporting boxes that are accessible in all Durand locations and as an electronic form for staff and other stakeholders on the Compliance portal of our Agency website: https://www.durandinc.org/#compliance. Or the Reporting Form can be mailed to our administrative office: Durand Inc., 304 Birchfield Drive, Mt. Laurel, NJ 08054 Attn: Compliance Officer for those who wish to mail a report, anonymously or not.

Your report will be received by our Compliance Officer for review, follow-up and response. No disciplinary action will be taken against any employee solely on the basis of a hotline report. However, all reports of misconduct will be fully investigated. We will treat each report confidentially to the extent permitted by law and will not take disciplinary action against, or tolerate any form of intimidation or retaliation against anyone who reports in good faith, regardless of the findings of our investigation. If you report fraud, waste or abuse in good faith, you are protected under CEPA as described above. Reporting in "good faith" means you are telling the truth as you know it. Making a report in "bad faith" means deliberately making a false accusation against someone and is a serious violation of this policy that may lead to disciplinary action against you, up to and including termination.

Any employee who believes he or she has been retaliated against for making a good faith report of a concern or issue should speak with our Compliance Officer. Any supervisor or member of our management team who retaliates against an employee for making a good faith report will be subject to disciplinary action, up to and including termination

Other ways to report information about fraud, waste or abuse in the Medicaid program are by writing or calling the DDD Compliance Officer, Division of Developmental Disabilities, P.O. Box 726, Trenton, NJ 08625, Phone: 800-626-6077 or calling the toll-free NJ Fraud and Abuse Hotline at 1-888-937-2835 or the federal HHS OIG toll-free hotline at 1-800-447-8477; or by calling or submitting a report to the New Jersey Medicaid Fraud Division at 888-

937-2835 or https://www.nj.gov/comptroller/divisions/medicaid/complaint.html or the New Jersey Insurance Fraud Prosecutor Hotline at 877-55-FRAUD or https://njinsurancefraud2.org/#report.