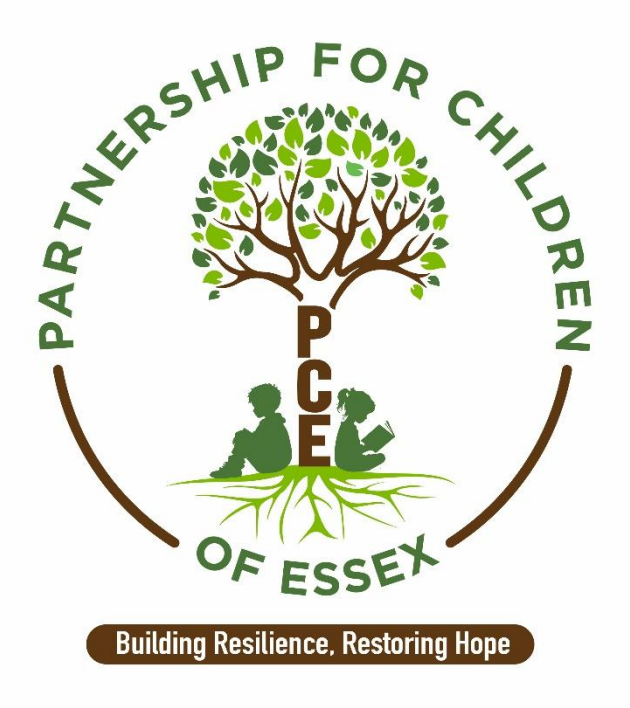

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Amended: August 21, 2025

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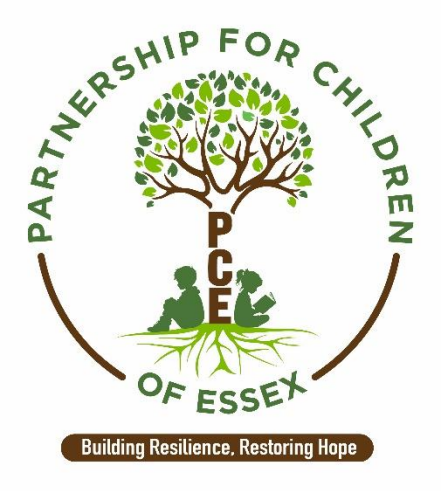

CORPORATE COMPLIANCE PLAN

SECTION I OF V

INTRODUCTION

I. INTRODUCTION

Partnership for Children of Essex, Inc. (referred to herein as the "Organization") is a non-profit and federally tax-exempt organization contracted by the New Jersey Department of Children and Families, Children's System of Care ("DCFCSC"). The Organization is dedicated to assisting children with emotional and behavioral challenges, children with intellectual and/or developmental challenges and children with substance abuse challenges and utilizes a Wraparound Model Care to provide services to children and families. The Organization uses this model of care to design, implement and manage Individual Service Plans that are specific to a child's individual strengths and complex needs. Emphasis is placed on the strengths of the child, family and community. The goal of the Organization is to keep children stable in their homes and their communities, where they belong.

The Organization is devoted to meeting and maintaining high ethical and professional standards and to do so through compliance with all applicable federal and state laws in the operation of its business. This commitment and dedication is essential to the Organization achieving its mission and is critical because a significant portion of services provided by the Organization are reimbursed through governmental programs which require that the Organization's business be conducted with integrity. In such regard, the Organization intends to treat its clients and to conduct its business in a manner that satisfies its ethical and legal obligations and its own high standards of integrity and quality. Toward this end, the Organization intends to comply with both the letter and the spirit of federal and state fraud and abuse and related laws, reimbursement laws and rules, and its lawfully executed contracts with third party payors and DCFCSC. In addition, as a non-profit corporate entity and federally tax-exempt organization, the Organization intends to comply with all requirements imposed upon such organizations.

To underscore and enhance its policy and pledge of compliance, and to provide its staff with the tools necessary to ensure compliance, the Organization is committed to this Corporate Compliance Plan (this "Compliance Plan"). This Compliance Plan is based on compliance guidance offered by the U.S. Department of Health & Human Services, Office of Inspector General and other available guidance. Implementation of this Compliance Plan is intended to assist the Organization in achieving and maintaining its goals of the delivery of quality services, integrity with respect to its participation in government and private health care reimbursement programs, and conduct that is in compliance with, and that promotes prevention, detection and resolution of behavior that does not conform to, federal and state laws and health care program requirements. This Compliance Plan has been approved by the Organization's Board of Trustees and represents official Organization policy.

A. Core Values.

This Compliance Plan is intended to underscore the Organization's mission and vision.

- MISSION: Working in partnership with youth, families, and the community, the Organization creates a pathway for hope and improves the quality of life for youth and their families in Essex County.

- VISION: The Organization is devoted to creating and sustaining a positive work environment that encourages personal growth and development. Using our Wraparound Model of Care with the youth and families we serve, we instill hope, resilience, and empowerment. Through our commitment to quality services, we excel as leaders in our field.

B. Responsibility.

It is the responsibility of every member of the Organization's staff, including its leadership, supervisors, administrators, office personnel and field staff (collectively, the "Staff Members") to comply with the policies and procedures implemented under this Compliance Plan. It is the responsibility of all Staff Members to identify compliance issues that may expose the Organization to liability for fraud or abuse under federal or state law or to other legal liability, so that such compliance issues may be promptly and appropriately addressed. Such efforts on behalf of the Organization will be a factor in performance evaluations for Staff Members, and failures to comply with this Compliance Plan will be met with consistent and appropriate remedial and disciplinary actions.

In addition to compliance with this Compliance Plan, Staff Members are expected to comply with all other policies and procedures of the Organization, including, but not limited to, policies governing OSHA compliance, HIPAA compliance and other compliance with law, policies governing employment and employment practices, and policies governing care management and administrative operations. Access to all policy and procedure manuals and documents of the Organization may be obtained from the CEO or Compliance Officer.

C. Objectives.

This Compliance Plan outlines the means by which the Organization will meet its ethical and legal obligations and its own high standards of integrity and quality, and by which it will foster a culture of compliance. If implemented as intended, this Compliance Plan will:

Promote the Organization's commitment to accurate submission of all claims to reimbursement programs in conjunction with the Organization's pledge of honest and responsible conduct.

Provide an effective internal control system that promotes adherence to and compliance with applicable federal and state reimbursement laws and regulations, and government and private health care reimbursement program requirements.

Promote the prevention, detection and resolution of instances of conduct that may not conform to federal or state laws and regulations, government or private health care reimbursement program requirements, or the Organization's ethical and business Code of Conduct.

Define responsibilities and establish accountability for compliance with federal and state laws and regulations and government and private health care reimbursement program requirements, and sustain a culture in which ethical conduct is recognized, valued and exemplified.

Educate Staff Members about the proper standards and procedures used in billing and coding to minimize billing mistakes and ensure early detection of any erroneous claims.

Provide a process through which Staff Members may identify and confidentially report to the Organization potential fraud, waste, abuse and noncompliance with federal or state laws and regulations, or government or private health care reimbursement program requirements.

Create a centralized source for the distribution of information on applicable federal and state laws, and government and private health care reimbursement program requirements.

Minimize, through early detection and reporting, any potential loss to the government from erroneous claims, as well as reduce the Organization's potential exposure to damages and penalties that might result from improper activities.

D. Benefits.

Implementation of this Compliance Plan as intended and full participation by Staff Members will assure the Organization's long-term success and will offer many benefits, including:

The development of effective internal procedures to ensure compliance with laws and regulations, payment policies and coding rules.

Improved client record documentation.

Improved education for Staff Members.

Reduction in the denial of claims.

More streamlined operations through better communication and more comprehensive policies.

The avoidance of potential liabilities arising from noncompliance.

Reduced exposure to penalties.

E. Summary of Plan.

This Compliance Plan includes this Introduction and the following four main sections, as well as appendices that include supplemental information and forms:

> **Section II - Code of Conduct.** This section sets forth the Organization's "code of conduct" to be followed by all Staff Members. The Code of Conduct draws from each of the other sections of this Compliance Plan and the Organization's Employee Handbook. It highlights key elements of the Compliance Plan and the standards against which efforts under this Compliance Plan may be measured. It sets forth the Organization's commitment to create a culture of compliance within the organization.

Section III - Compliance Practices and Procedures. This section includes important information about the Compliance Officer and Compliance Committee, the Organization's auditing and monitoring processes, compliance training and education, effective lines of communication for reporting suspected or actual incidents of non-compliance, responses to compliance concerns, and enforcement standards and disciplinary guidelines.

Section IV - Regulated Conduct and Guidelines. This section includes specific policies, procedures and guidelines intended to address important compliance matters, a summary of various federal and state fraud and abuse and other related compliance laws, information about government investigations, and information about compliance document recordkeeping and retention.

Section V – Federal Deficit Reduction Act Policy. This section includes the Organization's policy in compliance with the federal Deficit Reduction Act of 2005.

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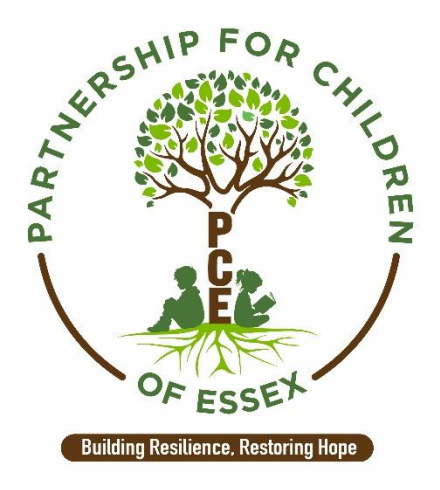

CORPORATE COMPLIANCE PLAN

SECTION II OF V

CODE OF CONDUCT

II. CODE OF CONDUCT

A. Introduction.

Partnership for Children of Essex, Inc. (referred to herein as the "Organization") is committed to conducting its business lawfully and ethically. To assure that the Organization's Staff Members (including the Organization's leadership, supervisors, administrators, office personnel and field staff) as well as Board of Trustees adhere to high standards of legal and ethical conduct, and to assure uniformity in standards of conduct, the Organization has established this Code of Conduct as part of the Organization's Compliance Plan.

This Code of Conduct establishes the general policies and procedures with which all Staff Members and Board of Trustees must comply. These policies and procedures are applicable to the Organization's relationships with government authorities and with private companies and individuals. These policies and procedures cannot cover all situations. Any doubts as to the propriety of a particular situation, whether or not the situation is described within this Code of Conduct or the Compliance Plan, should be submitted to the individual's immediate supervisor or the Organization's Compliance Officer.

This Code of Conduct is intended to assist the Organization in carrying out its mission, including to remind all Staff Members of their obligation to:

- Engage in carrying out the Organization's mission and vision in a professional manner, and in compliance with applicable laws and regulations.
- Recognize that the chief function of the Organization at all times is to serve the best interests of the Organization's clients and their families.
- Treat with respect and consideration all persons receiving services, regardless of race, religion, gender, sexual orientation, maternity, marital or family status, disability, age, national origin or other discriminatory factors.
- Demonstrate the highest standards of personal integrity, honor, truthfulness, honesty, and fortitude in all activities in order to inspire confidence and trust in such activities and uphold the dignity of the profession.
- Conduct organizational and operational duties with positive leadership exemplified by open communication, creativity, dedication, and compassion.
- Collaborate with and support other professionals in carrying out the Organization's mission.
- Strive for personal and professional excellence, including through continuing education, and encourage the professional developments of others.
- Respect and protect confidential and proprietary information, and access the same only in the performance of official business duties.
- Avoid any interest or activity that is in conflict with the conduct of official duties and responsibilities, or the mission and vision of the Organization.
- Respect the structure and authority of the Board of Trustees, and uphold, implement and comply with policies adopted by the Board of Trustees.

Compliance with this Code of Conduct and the Compliance Plan are criteria used in evaluating the performance of Staff Members. Violations of any of these policies and procedures will be addressed as specified in the Compliance Plan. This Code of Conduct may be revised from time to time, as the Organization deems appropriate. To the extent that any other policies or procedures are adopted by the Organization, such as those contained in the Organization's Employee Handbook, such other policies and procedures should be consistent with this Code of Conduct. In case of any inconsistency, this Code of Conduct governs.

COMPLIANCE WITH THIS CODE OF CONDUCT IS A CONDITION OF EMPLOYMENT OR OTHER ENGAGEMENT WITH THE ORGANIZATION. THIS CODE OF CONDUCT IS NOT, HOWEVER, A CONTRACT OF EMPLOYMENT OR OTHER ENGAGEMENT WITH THE ORGANIZATION, AND IT IS NOT INTENDED TO GIVE ANY EXPRESS OR IMPLIED RIGHTS OF CONTINUED EMPLOYMENT OR ENGAGEMENT WITH THE ORGANIZATION.

B. Oversight & Communications Regarding Compliance.

The Organization has designated a Compliance Officer, whose role is to assist the Organization in overseeing compliance with this Code of Conduct and the Organization's compliance policies and practices. The Compliance Officer works closely in conjunction with the Compliance Committee, and together the Compliance Officer and Compliance Committee oversee the compliance activities of the Organization.

The name of the Compliance Officer and the CEO, and the means for communicating with them, may be found posted in the employee cafeteria and on the Organization's intranet.

Any questions regarding this Code of Conduct and the Compliance Plan should be directed to the Compliance Officer or, in the absence of the Compliance Officer, the CEO. Actual or suspected violations of the Code of Conduct or Compliance Plan must be reported by utilizing the Organization's Safe Hotline to report your concerns. You may anonymously call or text Safe Hotline at 1.855.662.SAFE, or complete a complaint form at SafeHotline.com/SubmitReport. You must use PCE's Company ID (5681180846) when making your complaint. Suspected or actual violations also be may be reported to the Compliance Officer in person or by mail, telephone or email at Compliance_Manager@pcenj.org.

C. Quality of Services.

The Organization is committed to providing quality services to its clients and families. The Organization will monitor its performance against recognized standards, including, but not limited to, government healthcare and private reimbursement program requirements. Any deficiencies discovered by the Organization or any third party will be addressed. The Organization not only will respond to identified deficiencies, but will make reasonable efforts to be proactive by identifying and responding to quality risks prior to the occurrence of any deficiencies. Staff Members are excepted to assist the Organization in maintaining the high quality of services provided.

D. Preserving Privacy & Security.

1. Client Information.

We are entrusted by our clients with sensitive, personal and identifying information of a confidential nature. Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other federal and state privacy laws, we must maintain and protect "Protected Health Information" from inappropriate disclosures and uses. The Organization is committed to maintaining the privacy, confidentiality and security of this information.

Information is collected by the Organization's Staff Members regarding each client's demographics, social, family and medical history, and other sensitive or personal health information, as well as certain financial and benefits information, to provide appropriate quality services and seek reimbursement for such services. Under HIPAA, "Protected Health Information" (or "PHI") consists of any information that can identify an individual and that relates to the individual's health condition, treatment or payment for health care. PHI includes a broad range of information, whether in paper, electronic or oral format, including not only the individual's medical or related records and related information, but also billing information about the individual.

This information, which may be included in client records and in business records of the Organization, must be kept confidential and must be protected against theft, loss or improper disclosure. Consistent with the privacy regulations under HIPAA and other federal and state privacy laws and regulations, this information may not be disclosed unless otherwise permitted or required by law. **No Staff Member may view or access client health information other than as necessary to perform his or her job.** All uses and disclosures must be consistent with the Organization's privacy policies and procedures.

Inappropriate or unauthorized disclosures of confidential information may result not only in discipline by the Organization, but also may result in civil and financial penalties, and even criminal proceedings in egregious situations. Most importantly, the failure to maintain the privacy and security of our clients' information can break our clients' and their families' trust in the Organization and our services. **If you become aware of any unauthorized use, disclosure, theft or breach of PHI, you must immediately report it to the Organization's Privacy Officer or, in his or her absence, to the Organization's Compliance Officer.**

Staff Members are advised that confidentiality obligations extend even after termination from employment with the Organization.

2. Business Information.

Information regarding the Organization's strategies and operations are a valuable asset of the Organization, and such information is also confidential and proprietary to the Organization. This information includes, without limitation, business records and agreements; client lists and care management and related information; pricing and cost data; referral source information; information pertaining to acquisitions, affiliations and mergers; financial data and records; research data; strategic plans; marketing strategies; techniques; policies, procedures and

protocols; training materials; proprietary computer software; and information about, and data maintained on behalf of the Organization by, the Organization's vendors and suppliers. You should deem any document or computerized record of the Organization to contain the Organization's confidential and proprietary information. All Staff Members are obligated to protect and safeguard this confidential, sensitive, and proprietary information in a manner designed to prevent the unauthorized access, use or disclosure of this information. In addition, in the course of normal business activities, suppliers, customers and competitors may divulge information that is proprietary to their business. Such confidences should be respected and such information must not be disclosed beyond authorized purposes.

3. Record Retention.

The Organization will retain its business, client, billing and other records for such periods as required under applicable law. The Organization will retain and destroy such records in accordance with the Organizations document retention and destruction policy, as may be adopted or amended by the Corporate Compliance Committee from time to time.

E. Workplace Health & Safety.

The Organization is committed to maintaining a safe and healthy workplace. To that end, if you see any unsafe, hazardous or unhealthful condition in the workplace, you must immediately report the condition to your supervisor. If the condition is something you can easily remedy without harm to yourself (e.g., you find debris near a doorway entrance you can easily sweep up to prevent a tripping or slipping hazard), you should do so. Safety is everyone's concern and responsibility.

With respect to workplace health and safety, be reminded that:

1. You must follow the Organization's policies and procedures for workplace emergencies, such as fire, weather events and other emergency situations.

2. Threatening, aggressive, bullying or abusive behavior toward others is not tolerated at any time.

3. Weapons of any kind are not permitted on the premises of the Organization, including both its internal premises (the offices and building) and external premises (the parking lot and any real property belonging to the Organization).

4. The use of illegal or unauthorized drugs or the consumption of alcohol is strictly prohibited in the workplace. Likewise, reporting to work while under the influence of alcohol or illegal or unauthorized drugs, or smelling of alcohol or illegal/unauthorized drug consumption, can lead to discipline, up to and including termination. Likewise, the possession, sale, distribution or manufacture of any illegal drug, controlled substance or alcohol on Organization property, in an Organization-owned or supplied vehicle or during working hours is strictly prohibited. The storing of alcohol or any illegal or unauthorized drug or drug paraphernalia in a desk, vehicle or other repository on Organization premises is prohibited.

F. Workplace Conduct.

1. Employment Standards, Policies and Procedures.

The Organization has set forth in its Employee Handbook important standards, policies and procedures concerning employment practices and conduct of the Organization. All Staff Members are expected to understand and abide by the standards, policies and procedures set forth in the Employee Handbook, and such compliance is essential to the legal and ethical conduct promoted by this Code of Conduct.

2. Prohibited Harassment.

The Organization is an equal opportunity employer and has a policy of zero tolerance for workplace discrimination or harassment in the workplace.

The Organization implements policies that prohibit harassment of one employee by another employee, manager, supervisor or any other non-employees present in the workplace on the basis of any legally protected category including, but not limited to, a person's race, color, religion, creed, age, gender, pregnancy, national origin, ancestry, citizenship, affectional or sexual orientation, genetic information, marital status, domestic partnership/civil union status, liability for service in the armed forces of the United States, veteran status, handicap or disability, or atypical hereditary cellular or blood trait. Harassment is defined as verbal or physical conduct that denigrates or show hostility or aversion toward an individual because of that individual's membership in any protected group (for example, race, age, national origin, ancestry or disability) and that:

- Has the purpose or effect of creating an intimidating, hostile or offensive work environment;
- Has the purpose or effect of unreasonably interfering with the individual's work performance; or
- Otherwise adversely affects the individual's employment opportunities.

Sexual harassment has been defined by federal, state and/or local regulations as a form of sexual discrimination. Sexual harassment can consist of unwelcome sexual advances, requests for sexual favors, display of derogatory pictures or drawings, or other physical or verbal conduct by a supervisor or co-worker that unreasonably interferes with an employee's work performance or creates an intimidating work environment. The following list of prohibited conduct is not intended to be exhaustive since it is impossible to determine all the circumstances that may arise. It is illegal and against the policies of the Organization for any employee, male or female, to sexually harass another employee by:

- Making unwelcome sexual advances or requests for sexual favors or other verbal or physical conduct of a sexual nature a condition of an employee's continued employment;
- Making an individual, either male or female, an object of any unwelcome sexual advances in the course of his or her employment;

- Making submission to or rejection of such conduct the basis for employment decisions affecting the employee; or
- Creating an intimidating, hostile, or offensive working environment by such conduct.

While it is not easy to define precisely what harassment is, it certainly includes slurs, epithets, threats, derogatory comments, unwelcome jokes and teasing.

Under the law, individual employees, including directors, managers and supervisors, can be held personally liable for acts of harassment that they commit at work. Such personal liability could result in financial loss to the individual in addition to any sanction or discipline imposed by the Organization. The Organization does not condone and will not tolerate such conduct by its employees, trustees, directors, managers or supervisors either male or female.

Any employee who feels that he/she is a victim of such harassment should immediately report the matter to the Human Resources Director or SafeHotLine (1.855.622.SAFE or safehotline.com.. No retaliatory action will be taken against any employee who makes a good faith complaint of harassment and/or assists in the handling or investigation of a complaint in good faith. Employee complaints of harassment by managers and supervisors will be investigated in a fair and objective manner.

3. Social Media.

The Organization has devoted considerable time and resources to building its reputation and good will. These are valuable and important assets to the Organization. Your use of social media may negatively impact the Organization, so bear this in mind when using social media on your own time. You are solely responsible for your own conduct and you are solely responsible for what you post online. Before creating online content, consider some of the risks and rewards that are involved.

Keep in mind that any of your conduct that adversely affects your job performance, the performance of co-workers or otherwise adversely affects Organization management, clients, suppliers, vendors, people who work on behalf of the Organization or the Organization's legitimate business interests, may result in disciplinary action up to and including termination. Further, unless an Authorization for PHI Use in Marketing form has been completed by the client or family, posting of client and family information, even if you think you are being anonymous or trying to "de-identify" the information, may be a breach of your legal obligations under HIPAA and other privacy laws, resulting in potential civil and criminal penalties imposed upon you personally. Only designated PCE employees assigned to manage its social media and marketing may post client/family PHI once the authorization form is signed.

4. License, Registration and Certification Renewals.

All licensed, registered and certified Staff Members are responsible for maintaining and ensuring the validity of their respective licenses, registrations and certifications or other credentials. All licensed, registered and certified Staff Members shall comply at all times with

federal and state laws and regulations affecting their respective disciplines and governing the practice of their respective professions.

5. Use of the Organization's Property.

As a general rule, Staff Members are expected to use the Organization's assets, including time, materials, supplies, equipment, information and other resources ("Assets") in a prudent and effective manner for business-related purposes only. The use of Assets for community or charitable purposes, or for personal uses, must be approved by supervising Staff Members, in advance. Any use of Assets for personal financial gain unrelated to job responsibilities on behalf of the Organization is prohibited.

G. Ethical and Legal Compliance.

1. Compliance.

Staff Members are expected to engage in ethical and legal conduct at all times. Staff Members must comply with all applicable federal, state and local laws and regulations, and government health care and private reimbursement program requirements to which the individual and Organization is bound by law or pursuant to lawfully executed contracts. This compliance requirement includes all licensure rules and regulations, and all applicable legal, ethical and professional standards of practice. Staff Members must comply with this Code of Conduct, the Compliance Plan and all other policies, procedures and protocols adopted by the Organization from time to time.

Staff Members are expected to act in a legally- and ethically-compliant manner at all times and within the scope of their employment and job duties and limitations at all times. Each Staff Member should be aware that actions taken by the Staff Member that are unethical, illegal or outside the scope of employment or beyond job duties may subject the individual Staff Member to personal liability. This may include, for example, civil liability, professional licensure board liability and potential criminal liability. This also may include employment sanctions, up to and including termination of employment.

To assist Staff Members in understanding and meeting their compliance obligations, all Staff Members are expected to attend general compliance education and training sessions as well as more specific sessions designated for their areas of responsibility and job titles. This may include mandatory compliance training offered by the Organization, as well as continuing education courses offered outside the Organization. Staff Members holding a professional license, certification or registration also must comply fully with all professional continuing education requirements.

The laws, rules, regulations, policies and procedures to which Staff Members are bound are extensive and subject to change. Although the Organization will assist staff Members in understanding and meeting their compliance obligations, each Staff Member is required to read and understand the Organization's Compliance Plan and this Code of Conduct, as well as other policies and procedures of the Organization, and to act in a compliant manner at all times when acting or providing services to or on behalf of the Organization. Further, each Staff Member is

obligated to further his or her own education by keeping abreast of legal, professional and compliance developments.

Compliance questions should be directed to the Compliance Officer who will answer directly or obtain information as needed to answer specific questions.

2. Leadership.

While all Staff Members are expected to comply with this Code of Conduct, those in a leadership position, such as those in management, supervisory roles or other positions of authority, are expected to serve as role models. Such individuals are expected to ensure that those under their direction and supervision have sufficient information and guidance to be able to comply with applicable federal and state laws, regulations and policies, and to resolve ethical dilemmas. Individuals in leadership positions must strive to promote an appropriate standard of ethical and legal performance.

3. Reporting.

Staff Members are required to report immediately to the Organization's Compliance Officer or, in the absence of the Compliance Officer the CEO, any actual or perceived violation of law, this Code of Conduct, the Compliance Plan, or any other policies or procedures adopted by the Organization. The Organization takes all reports of non-compliance seriously, and all reports made in good faith may be made without fear of retribution or retaliation. The Organization will make efforts to maintain the confidentiality of any individual reporting misconduct; however, confidentiality cannot be guaranteed as requirements of applicable law and the circumstances associated with the misconduct may require or result in disclosure.

Reports may be made by sending a message through the Organization's Safe Hotline to report your concerns. You may anonymously call or text Safe Hotline at 1.855.662.SAFE or complete a complaint form at SafeHotline.com/SubmitReport. You must use PCE's Company ID (5681180846) when making your complaint. The reporter is encouraged to provide as much information as possible to assist with the issue at hand. Reports may also be made to the Compliance Officer in person, by mail, telephone or email at Compliance_Manager@pcenj.org.

It is the Organization's policy that no Staff Member will be disciplined for the good faith reporting of what is reasonably believed to be an act of wrongdoing or a violation of law, this Code of Conduct or the Compliance Plan. However, a Staff Member may be subject to disciplinary action if it is reasonably determined that the report of wrongdoing was knowingly fabricated, distorted, exaggerated or minimized to either injure someone else or to protect others. Further, a Staff Member whose report of potential misconduct contains admissions of personal wrongdoing will not be guaranteed protection from potential disciplinary action. The fact of an admission, however, as opposed to deliberate non-reporting, will be taken into consideration in connection with making a disciplinary decision, and depending on all of the relevant circumstances, may result in a lesser disciplinary action than would result in the event of non-reporting.

4. Investigation.

It is the responsibility of the Compliance Officer to ensure that each report of potential violations is appropriately documented and promptly investigated. It is the responsibility of the Compliance Officer to ensure that an objective and informed version of the facts is uncovered during the investigation, and that each matter investigated is brought to a satisfactory conclusion. The Compliance Officer will periodically inform the Organization's Compliance Committee, CEO, Board of Trustees and, if appropriate, its legal counsel of the reports received and the investigations conducted. When necessary, the Compliance Officer will work with the Compliance Committee to investigate compliance matters. If the compliance matter potentially involves in any way the Compliance Officer, other members of the Compliance Committee will be responsible for ensuring the prompt investigation and satisfactory conclusion of the matter. Staff Members are expected to cooperate fully in the investigative process.

5. Corrective Actions.

The Organization does not promote or condone unethical conduct or criminal activity in any context. The Organization recognizes, however, that the laws, regulations, rules and policies applicable to Staff Members are complex and often subject to interpretation. The Organization also understands that mistakes may occur. Accordingly, the Compliance Officer and Compliance Committee are charged with the obligation to assess all of the relevant facts and circumstances surrounding reported misconduct and to recommend appropriate corrective actions.

The Organization is committed to correcting legal and ethical wrongdoing to assure that the Organization's Staff Members adhere to both the letter and spirit of the applicable federal and state laws and standards. The Organization's corrective actions may include further training and education, amendment or clarification of policies and procedures, or creating and implementing new policies and procedures. Corrective actions also may include, as deemed necessary or appropriate under the circumstances, disciplinary actions in respect to the individual or individuals involved in the misconduct, including employment termination and, if appropriate, referral to government or law enforcement authorities for further action. All Staff Members are expected to cooperate fully with any corrective actions adopted by the Organization.

H. Avoiding Abuses of Trust.

1. Conflicts of Interests; Disclosure.

Staff Members are expected to avoid engaging in any activity that might interfere or appear to interfere with the independent exercise of professional or business judgment, such as when a Staff Member's personal interests conflict with the best interests of the Organization or its clients or business partners.

A conflict of interest may arise if personal interests or outside activities influence, or appear to influence, the ability to make objective decisions related to job responsibilities, or to act in a manner that is in the best interests of the Organization. Conflicts of interests arise when a person is in a position to derive personal benefit from actions or decisions made in their official capacity. Although it would be difficult to provide an exhaustive list of examples, some examples

include having a financial relationship or investment interest in a business vendor doing business with the Organization, familial relationships on the or the workplace, a manager having a romantic relationship with a Staff Member who reports to the manager, or receiving a gift from any entity or individual that could be viewed as trying to influence a decision on behalf of the Organization.

Staff Members with decision making authority, including the Compliance Officer, Members of the Compliance Committee, , managers and supervisors, and others who make decisions on behalf of or that affect the Organization must disclose actual and potential conflicts of interest to the Compliance Committee. The CEO and members of the Board of Trustees must disclose actual and potential conflicts to the Board of Trustees Executive Committee. Failure to disclose a conflict of interest will lead to disciplinary action, up to and including termination. All actual and potential conflicts will be reviewed and appropriate actions taken. Refer to the Organization's Conflict of Interest Policy, as may be adopted or amended by the Corporate Compliance Committee from time to time.

2. Receiving Gifts from Clients and their Families.

Clients and their families may occasionally wish to give gifts to Staff Members as a token of appreciation. By accepting such gifts, however, Staff Members may create expectations of favored status or preferential treatment to the clients or families. Accordingly, Staff Members must consider the circumstances before accepting any gift, and must consult with the Compliance Officer before accepting any gift that could be considered extraordinary or otherwise unreasonable under the circumstances. Under no circumstance may a Staff Member solicit gifts from clients or their families, business vendors or others doing business with the Organization. The Organization may, from time to time, adopt policies and procedures concerning gifts from clients and families, or rule on any specific gift of which it becomes aware.

3. Receiving Business Courtesies from Referral Sources.

Business courtesies may not be solicited under any circumstances. No Staff Member may accept anything of value from someone doing business with the Organization if the business courtesy is offered or appears to be offered in exchange for any type of favorable treatment or advantage or is for or to influence the referral of clients or other reimbursable business from or to the Organization. Staff Members must never give to or receive from any vendor or potential vendor any bribe, kickback or other unusual payment. Federal and state laws and regulations specifically prohibit the offer or acceptance of a bribe, kickback or other thing of value in exchange for or to induce a referral or other business.

To avoid even the appearance of impropriety, Staff Members are not to accept any gifts. Additionally, staff members are not to accept promotional items of more than nominal value without express written approval of the Compliance Officer or CEO. "Nominal value" means valued at no more than $15.00 retail value per item or $75.00 in the annual aggregate. All gifts received that are valued in excess of $15.00 retail value per item or $75.00 in the annual aggregate must be reported to the Compliance Officer or CEO.

4. Giving Business Courtesies to Clients or Referral Sources.

The Organization does not seek to gain an improper advantage by offering business courtesies such as entertainment, meals, or free services to clients, referral sources or purchasers of the Organization's services. Staff Members should not offer any type of business courtesy to a referral source or a client for the purpose of obtaining favorable treatment or advantage. To avoid even the appearance of impropriety, Staff Members must not provide any referral source or client with gifts or promotional items of more than "nominal value," as defined above.

5. Professional Courtesies for Staff Members.

The Organization may, from time to time, adopt policies concerning professional courtesies/discounts for Staff Members of the Organization, as well as other individuals. It is imperative that any such policy be carefully applied because the policy and the actual courtesies extended must comply with federal and state law requirements. Currently, no such policy applies or can apply to beneficiaries of any federal healthcare benefit program, such as Medicare and Medicaid, unless there has been a good faith showing of financial need. Any Staff Member who may have a concern or question concerning such policies should speak with the Compliance Officer.

I. Business Practices.

1. Binding the Business Entity. At a business level, the Organization consists of a non-profit corporation: Partnership for Children of Essex, Inc. The activities and affairs of the corporation are overseen by a Board of Trustees, with day-to-day affairs managed by the CEO. Unless expressly authorized or granted in a written document signed by the President of the Board of Trustees or the CEO, no Staff Member shall have the power or authority to take any action, make any commitment or sign any contract or other instrument for, in the name of, on behalf of, or in any other way that will bind or commit the Organization, or impose any commitment or obligation on the Organization. This includes, but is not limited to, a financial, performance or legal commitment or obligation.

2. Relationships with Contractors, Suppliers and Vendors.

The Organization will manage its contractor, supplier and vendor relationships in a fair and reasonable manner, consistent with all applicable federal and state laws and regulations. The Organization's selection of contractors, suppliers and vendors will be made on the basis of objective business criteria and not be based on personal relationships and friendships. The Organization expects its Staff Members to maintain ethical conduct when engaging in business practices such as source selection, negotiation, determination of contract awards, and administration of purchasing activities.

3. Government Customers.

The Organization may from time to time be a party to various contracts and subcontracts with government agencies. Examples are provider contracts wherein the Organization supplies services to or on behalf of the governmental programs, such as Medicaid, either directly or as a subcontractor. It is essential that all Staff Members are knowledgeable of, and comply with, all of the applicable federal and state laws, rules and regulations of all such

government agencies. Billing personnel must also comply with the Organization's policies and procedures regarding billing and reimbursement. Any Staff Member who may have a concern or question concerning compliance with any government contract or subcontract should report the concern to the Compliance Officer.

4. Kickbacks and Other Inducements.

Staff Members shall not solicit, offer, receive or pay any financial inducement, gift, payoff, kickback or bribe to induce, influence or reward favorable decisions of any government personnel or representative, any customer, contractor, or vendor in a commercial transaction, or any person in a position to benefit the Organization or other Staff Members in any way. Staff Members are prohibited from engaging in any such unlawful business practices, either directly or indirectly. Staff Members shall not make or offer payment or provide any other thing of value to another person with the understanding or intention that such payment or other thing of value is to be used for an unlawful purpose.

5. Billing and Financial Reporting.

The Organization is committed to ensuring that the Organization's billing and reimbursement practices comply with all federal and state laws, regulations, guidelines and policies, as well as any third party payor requirements, and that all bills and claims are accurate and reflect current payment methodologies. Staff Members must use their best efforts to prevent, and if appropriate, to report to the Compliance Officer or, in the absence of the Compliance Officer the CEO, errors, improprieties or suspicious circumstances in billing that could violate applicable federal and state laws or regulations, or any of the Organization's policies or procedures.

Staff Members must be familiar with the Organization's billing and reimbursement policies and procedures. Staff Members shall be honest and accurate in documenting and coding for services rendered, filing claims for reimbursement, seeking payment for services rendered and maintaining financial records. Staff Members shall not submit false, fraudulent or misleading bills or claims to any client, any government entity or third party payor, including, but not limited to, bills or claims for services not provided or that characterize the service differently from the actual service, or that do not otherwise comply with applicable program or contractual requirements.

The Organization does not knowingly contract with, employ, or bill for services rendered by an individual or entity that is excluded or ineligible to participate in federal or state health care programs, or that is suspended or debarred from federal or state government contracts, or that has been convicted of a criminal offense related to the provision of health care items or services. Staff Members immediately shall report to the Compliance Officer or, in the absence of the Compliance Officer the CEO, any information Staff Members may possess concerning the exclusion, suspension, debarment or other ineligibility of the Staff Member, other Staff Members or other individuals or entities with which the Organization has or is considering a business relationship.

Although it is difficult to provide a comprehensive list of impermissible activities, the following are examples of prohibited conduct:

- Billing for services not provided.
- Altering forms or documentation to obtain payment.
- Engaging in deliberate or a pattern of duplicate billing to obtain reimbursement to which the Organization is not entitled.
- Offering, paying, soliciting or receiving any kickback, bribe or rebate.
- Misrepresenting services rendered, the identity of the person providing a service, the dates of services, or frequency, duration or description of services.
- Billing for non-covered services as covered services.
- Intentionally or recklessly submitting incorrect, misleading or fraudulent information to a payor.
- Intentionally falsifying, destroying or withholding records relating to billing and claims submission functions.

6. Antitrust and Competition.

Staff Members are expected to comply with applicable antitrust laws and similar laws regulating competition. Staff Members must not engage in any behavior that might interfere with fair competition. For example, state and federal antitrust laws prohibit price fixing, which includes sharing price or cost data with competitors. These laws also prohibit boycotts, certain exclusive dealing and price discrimination agreements against competitors, vendors or purchasers, and similar unfair practices, including bribery, misappropriation of trade secrets, deception and intimidation. In general, sensitive conversations with competitors or suppliers should be avoided except through the advice of legal counsel.

Staff Members must not provide the Organization's business information to a competitor, unless the provision of such information is necessary to consummate a *bona fide* business relationship or to serve a joint child/family receiving services from both organizations. Any business information provided must be strictly limited to that necessary for the particular business relationship or services provided.

7. Improper Influence on Conduct of Audits.

No Staff Member, including any director, officer, or supervisor, or any Trustee or other individual, or any person acting at the direction of any such individual, shall directly or indirectly take action to coerce, manipulate, mislead or fraudulently influence any public accountant, certified public accountant, auditor or other financial advisor or contractor engaged in the performance of any audit or review of financial statements of the Organization, which could result in rendering the Organization's the audit results or financial statements false or materially misleading.

8. Marketing and Advertising.

The Organization may engage in marketing and advertising activities to educate the public, increase awareness regarding services offered, and recruit staff. The Organization will present only truthful, non-deceptive information in marketing materials. Staff Members shall be honest in communications with clients and their families, attorneys, auditors and with all those

with whom the Organization does business. Staff members shall not make any misleading statements about the Organization's services or products or those of its competitors.

J. Tax-Exempt Status.

1. Generally.

The Organization is a not-for-profit corporation and has been granted federal tax-exempt status by the Internal Revenue Service (IRS) based upon our Organization's charitable mission. Maintaining this status is critical, and the use of the Organization's tax-exempt assets and revenues must meet all applicable IRS requirements. For example, our Organization may not engage in activities that inappropriately benefit private organizations or individuals, including Staff Members and members of the Board of Trustees. If a private benefit is more than incidental, it may jeopardize the Organization's tax-exempt status. This is to ensure that the Organization serves a public interest, not a private one. The Organization is committed to serving its charitable mission and maintaining its tax-exempt status.

2. Political Contributions.

As a tax-exempt organization with a not-for-profit corporate status, the Organization must remain unbiased and objective during political campaigns and elections. Staff Members are not permitted to participate or intervene in political campaigns on behalf of (or in opposition to) any candidate for public office in the capacity of their position with the Organization. If you have any questions about your individual participation or funding of a political campaign, contact the Compliance Officer. The following "do's" and "don'ts" provide some general guidelines:

Do's:

- You may contribute personal funds to the candidacy of a public official, subject to applicable law.
- You are free to be involved in the democratic process during your personal time away from work, so long as you are speaking for yourself as an individual and are not presenting yourself as a representative of or speaking on behalf of the Organization.

Don'ts:

- You may not receive reimbursement from the Organization for contributions to political activities.
- You may not use Organization resources, property, assets or facilities for any political activities.
- You may not use Organization funds to contribute to a political campaign or election in any way.

K. Non-Retaliation.

The Organization is committed to operating with honesty and integrity in all aspects of its business. The rules under which our Organization and Staff Members must operate are often complex and difficult to understand. It is every Staff Member's obligation to raise compliance questions and concerns with the Compliance Officer, CEO or a supervisor (who should bring the matter to the Compliance Officer or CEO for response).

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

L. Acknowledgement Process.

Staff Members and members of the Board of Trustees are expected to read and comply with this Code of Conduct. Questions concerning this Code of Conduct should be directed to the Compliance Officer. Each Staff Member and Board Member is expected to sign and return to the Organization a written acknowledgement that he or she has read this Code of Conduct, understands its terms and agrees to comply with it.

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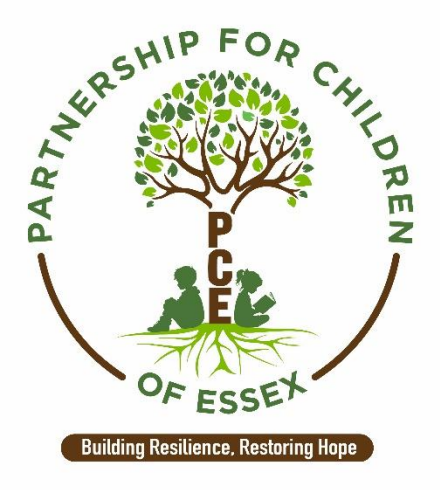

CORPORATE COMPLIANCE PLAN

SECTION III OF V

COMPLIANCE PRACTICES AND PROCEDURES

III. COMPLIANCE PRACTICES AND PROCEDURES.

A. Plan Applicability and Distribution.

1. Applicability.

Partnership for Children of Essex, Inc. (referred to herein as the "Organization") has instituted these compliance practices and procedures as part of its Corporate Compliance Plan. The Compliance Plan applies to the Organization's Staff Members, including the Organization's leadership, supervisors, administrators, office personnel and field staff, as well as all contractors and agents of the Organization involved, directly or indirectly, in the provision of or billing for health care services to any government or private third party payor.

2. Distribution.

The Compliance Plan will be distributed in its entirety to the Organization's Staff Members. The Code of Conduct will be distributed to all Staff Members and the Organization's independent contractors and agents.

3. Updates.

The Compliance Plan will be updated or supplemented as soon as practicable following the enactment, promulgation or publication of any new law, regulation, official government interpretative guidance or valid contractual modification affecting any government or private third party payor, including, but not limited to, reimbursement, coding, billing, documentation or medical policy changes, or the publication of any binding case law precedent in the states in which the Organization provides services or which represents persuasive precedent to the courts of such jurisdictions.

B. Compliance Officer.

1. Appointment; Term of Office.

The Organization shall appoint a Compliance Officer whose role is to serve as the focal point for organization-wide compliance activities and to plan, implement and monitor the various elements of the Organization's compliance program. The Compliance Officer shall serve as a member of the Organization's Compliance Committee. The Compliance Officer may be removed from office or replaced at any time, for any reason, by vote of the Compliance Committee. The Compliance Officer will not have a right to vote on such matter.

2. Duties and Responsibilities of the Compliance Officer.

The Compliance Officer has responsibility for the administration and management of this Compliance Plan and shall act as Chair of the Compliance Committee. In his or her role as Compliance Officer, the Compliance Officer reports directly to the Compliance Committee and the CEO. The Compliance Officer shall have direct access to the Organization's legal counsel, within the budgetary restrictions of the Organization. Notwithstanding any such budgetary restrictions, the Compliance Officer shall have direct unimpeded access to the Organization's legal

counsel (a) when determined necessary in light of the urgency of the matter (e.g., situations that can result in immediate consequences to the Organization) and/or (b) the sensitivity of the matter makes direct access necessary (e.g., when there is an internal unresolved conflict). The Compliance Officer must be accessible to all Staff Members. The responsibilities of the Compliance Officer include:

a. Implementation. The Compliance Officer shall oversee the development, implementation, administration and day-to-day enforcement of the Compliance Plan. The Compliance Officer shall periodically recommend to the Compliance Committee revisions to the Compliance Plan in light of changes in the Organization's needs and applicable federal and state laws and regulations. The Compliance Officer shall ensure distribution of the Code of Conduct and the entire Compliance Plan, in accordance with **Section III.A.(2)**, and obtain a written acknowledgment from all Staff Members acknowledging their understanding of, and commitment to abide by, its requirements.

b. Staff Communication. The Compliance Officer shall assist in the development and implementation of policies and procedures to provide a mechanism for reporting potential compliance issues or violations of the Compliance Plan and that encourage all Staff Members to report suspected compliance issues to the Compliance Officer or the CEO without fear of retaliation for good-faith reporting.

c. Reports to the Compliance Committee and the CEO. The Compliance Officer shall report periodically (at least bi-annually) to the Compliance Committee and CEO. The reports will address, as appropriate, the progress of implementation, or any review and revision of, the Compliance Plan; incidents of suspected misconduct or other non-compliance; and the initiation and progress of any investigation in response to a complaint or any periodic audit, and the findings and recommendations in respect to any investigation or periodic audit. The Compliance Officer also shall have the authority to report on such matters directly to the Compliance Committee, the CEO and the Board of Trustees at any time.

d. Education. The Compliance Officer shall oversee development, approval and monitoring of the educational and training materials and programs relating to this Compliance Plan, and facilitate and participate in educational and training programs focusing on essential components of this Compliance Plan and the policies and procedures adopted or otherwise referred to under this Compliance Plan.

e. Investigation and Corrective Actions. The Compliance Officer, with the assistance of the Compliance Committee where appropriate, shall independently investigate matters related to compliance, including designing and coordinating internal investigations in response to complaints or reports of problems or suspected violations. In consultation with and subject to approval by the CEO, and with the advice of the Organization's legal counsel when appropriate, the Compliance Officer shall determine, oversee and monitor any appropriate corrective or disciplinary actions. The Compliance Officer shall maintain a log of all compliance reports of complaints, investigations and actions taken.

f. Periodic Audits. The Compliance Officer shall ensure an appropriate quality assurance program is in place in order to identify potential audit areas, establish

audit priorities, and conduct periodic audits in order to improve the Organization's efficiency and quality of services, to monitor compliance, and to reduce the Organization's vulnerability to fraud and abuse. (See Appendix 5 for Billing Audit Plan.)

g. Background Checks. The Compliance Officer shall oversee the performance of background checks and screening on all newly hired individuals, current employees and vendors pursuant to this Compliance Plan.

C. Compliance Committee.

1. Appointment; Term of Office; Qualifications.

The Organization shall appoint and maintain a Compliance Committee consisting of the following voting members: (a) the CEO; (b) the Compliance Officer; (c) the HIPAA Privacy Officer; (d) the HIPAA Security Officer; (e) the Quality Assurance Director; (f) two members of the Board of Trustees, one of whom shall be the Board President; (g) the Director of Operations; (h) a Supervisor; (i) a Care Manager; (j) the Director of Human Resources and (k) other such other members as determined by the Compliance Committee. The members appointed to the Compliance Committee shall serve until such members' resignation or removal. Any member of the Compliance Committee may resign from the committee at any time upon at least sixty (60) days advance written notice to the Corporate Compliance Officer. A member of the Compliance Committee, including the Compliance Officer, is automatically deemed to have resigned from the committee and, as applicable, the office, immediately upon the expiration or termination of the individual's employment, other engagement or position with the Organization. Any Compliance Committee member may be removed or replaced at any time, for any reason, by the Corporate Compliance Officer in consultation with the CEO.

The Corporate Compliance Officer in conjunction with the CEO shall determine the number and qualifications of the individuals comprising the Compliance Committee, and it may assign specific obligations under this Compliance Plan to the various members. The Corporate Compliance Officer in conjunction with the CEO may change the number of members, the required qualifications of the members, and its assignment of obligations as and when it deems necessary or desirable to address the needs of its clients and business operations..

2. Duties of the Committee Members.

a. Duty of Loyalty. The primary obligation of each member of the Compliance Committee is a duty of loyalty to the Organization. Accordingly, each member of the Compliance Committee agrees to act fairly and honestly with the Organization, without self-interest or other undisclosed or improper motives, and to promote ethical and legal conduct.

b. Confidentiality. Compliance Committee members are obligated to keep strictly confidential all information relating to the Organization's operations and all information relating to the Compliance Committee's activities. Unless required by law, Compliance Committee members must not disclose any such information to a third party without the prior authorization and consent of the Organization's Compliance Officer in consultation with the CEO. Compliance Committee members must not disclose any of the committee's activities to

any Staff Member unless such disclosure is required under this Compliance Plan or otherwise for the committee member to carry out his or her duties for the Compliance Committee. If a member of the Compliance Committee is requested or required to disclose any such information to a third party, the committee member must provide the Organization with prompt notice of the request or requirement before disclosing the information (unless such notice is prohibited by law) so as to afford the Organization an opportunity to seek an appropriate protective order. Compliance Committee members will be obligated to enter into a confidentiality agreement setting forth these requirements, in a form substantially the same as the form included in the Appendix to this Compliance Plan.

3. Responsibilities of the Committee.

The Compliance Committee shall endeavor to fulfill the following obligations and functions:

a. Meetings. The committee shall meet at least bi-annually and at such other times as requested by the committee Chair or other member of the committee, or as needed in order to respond to compliance issues. The committee shall act by a simple majority vote of all members of the committee. The committee shall maintain records of its meetings and actions.

b. Review of this Compliance Plan. The committee shall review this Compliance Plan periodically (at least every two years) and, following consultation with the Compliance Officer and legal counsel, it shall propose revisions to this Compliance Plan in response to its findings and in response to changes in the needs of the Organization, changes in federal or state law, and changes in policies and procedures of government and private third party reimbursement programs.

4. Authority.

Subject to the ultimate authority of the CEO , the Compliance Committee is hereby granted authority commensurate with its responsibilities, including, without limitation, the authority to conduct or oversee the conduct of investigations and audits, to interview Staff Members and contractors and members of the Board of Trustees, and to review all documents and other information relevant to compliance activities, including client records, billing records, appointment records and records concerning the marketing efforts of the Organization and the Organization's arrangements with other contractors or entities, and the authority to enforce the approved corrective actions. The Compliance Committee may seek advice of legal counsel to ensure that the Organization does not violate any false claims act laws, anti-kickback prohibitions, self-referral prohibitions, or any other legal or regulatory obligation.

5. Limitations on Responsibilities.

It should be clearly understood that neither the Compliance Committee, nor the Compliance Officer, is responsible for the Organization's actual compliance with applicable federal and state laws, rules and regulations or for transacting business in conformance therewith. Rather, the Compliance Committee and the Compliance Officer are responsible for ensuring that the Organization has in place, at all times, an effective compliance plan, and that the applicable

policies and procedures of the Organization are sufficient for purposes of communicating, monitoring and enforcing the Organization's ongoing commitment to compliance. That being said, each individual is responsible for such individual's own conduct.

D. Auditing and Monitoring Process.

1. Monitoring Reports.

The Organization, through the Compliance Committee, shall create periodic compliance reports outlining the activities of the Organization with respect to implementation, maintenance and amendment of this Compliance Plan. If a complaint or other report alleging known or suspected non-compliance has been filed, the Organization, through the Compliance Committee, may, as appropriate, prepare a special compliance report that describes the alleged or suspected non-compliance and the actions taken and the recommendations made in response to the complaint or report. The special compliance report should include the following information:

- The circumstances that led to the complaint or report.
- The investigative steps that were taken.
- The facts disclosed during the investigation.
- The applicable federal and state laws or regulations at issue.
- The internal policies, procedures or practices at issue.
- The conclusions reached by the Compliance Committee or the Organization and the remedial actions recommended or taken, if any, or as applicable, the referral of the matter to the Organization's legal counsel.

2. Audits; Auditors' Expertise.

The Organization shall cause to be conducted periodic audits of the Organization's billing and coding compliance, as more fully described below. (See Appendix 5 for description of Billing Audit Plan)The frequency of such audits shall be as determined by the Compliance Officer, in consultation with the CEO and Compliance Committee. The Organization shall ensure that internal or external auditors conducting these compliance audits have expertise in federal and state reimbursement laws, and government and private health care reimbursement program requirements, including, as necessary, billing, coding and documentation rules. When possible, the Organization will have its legal counsel engage the chosen external audit company and have the audit performed at the direction of its legal counsel in order to establish the attorney-client privilege to audit communications and results.

3. Audit Subjects and Goals.

The specific subjects and goals of each audit should be determined by the Compliance Officer, in consultation with the CEO and Compliance Committee, as appropriate, and the Organization's outside consultants when appropriate, and may be based upon the subjects and goals specified in this Compliance Plan (such as with respect to claims submission audits) or based upon a response to a specific complaint or report of suspected non-compliance or other findings. Determination should be made as to the following:

a. Type of Review. Determination should be made whether a particular audit will be "random" (based on a random selection of records reflecting a representative sample of the Organization's mix) or "focused" (based on a selected sample of records from a pre-identified problem or area/specialty/service).

b. Scope of Audit. Determination should be made as to whether a particular audit will be "prospective" (review of records *prior to* claims submission) or "retrospective" (review of records *after* claims submission and reimbursement from the insurance carrier).

c. Sample Size. Determination should be made as to the size of the audit and number of records to be audited.

4. Claims Submission Audits.

a. Goals. The goals of any claims submission audit are to determine whether (i) bills are accurately coded and accurately reflect services provided, (ii) services or items provided are medically necessary, (iii) any incentives for unnecessary services or items exist, and (iv) client records contain sufficient documentation to support the charge billed.

b. Baseline Audit. The Organization may cause to be conducted a baseline claims submission audit following the implementation of this Compliance Plan. This baseline audit should examine the claim development and submission process, from client intake through claim submission and payment, and identify elements within the process that may contribute to non-compliance or that may need to be the focus for improving execution. This baseline audit should establish a methodology for selecting and examining client records, which may serve as the continuing methodology for future claims submission audits.

c. Periodic Audits. The Organization shall cause to be conducted periodic claims submission audits at such times as determined by the Organization. The methodology for selecting and examining the medical records under the periodic audits should be consistent with the methodology established under the baseline audit, if any, subject to adjustments deemed reasonably necessary to address deficiencies discovered in the audit process or changes in circumstances.

d. Focus. All claims submission audits should be designed to achieve the goals set forth above, but such audits may also focus on (i) the specific risk areas identified by the Organization, including particularly documentation of medical necessity, confirmation that all services ordered were actually performed and documented and that only those services were billed, (ii) a review of codes and modifiers assigned to claims, (iii) discovery of data entry errors, or (iv) the examination of the Organization's most frequent claim-denials or the Organization's most frequent claims (e.g., the top ten denials or the top ten services billed).

5. Response to Problems.

If any of the audits conducted by or on behalf of the Organization identifies a compliance problem, such as in coding and billing, the Organization shall promptly evaluate the

problem and appropriately respond. The evaluation and response may be made in consultation with the Organization's advisors, including its legal counsel. The response depends upon the circumstances, and may include, among other actions, modification of the Organization's standards and procedures, additional training and education of Staff Members, and, in the case of an overpayment or incorrectly submitted claim, notice and return of the overpayment to the applicable payor or re-submission of the corrected claim.

6. Audit Process.

The Organization, in consultation with its advisors, including its legal counsel, shall determine from time to time the auditing processes that best suit the subjects and goals of each audit, the needs of the Organization, and the requirements of this Compliance Plan. Internal or external auditors may perform the audits, and the auditors may utilize, among others, any of the following techniques: concurrent or retrospective audits; spot-checking the work of coders and billers; on-site visits and interviews of clients and their families at their homes; interviews with personnel involved in coding, claims development and submission, care management, and other related activities; questionnaires; testing billing and coding staff to determine their knowledge of reimbursement and coverage criteria; assessing existing relationships with providers, facilities, and other potential referral sources; reevaluation of deficiencies cited in past surveys; and review of client and financial records of the Organization. Any external auditor retained should be independent of the care management staff/professionals of the Organization.

7. Documentation Requirement.

The Organization shall appropriately document its auditing efforts, and it shall maintain this documentation, including its internal and external audit reports, in a central file dedicated to the Organization's compliance activities. All documents relating to auditing activity should be marked, "CONFIDENTIAL," and any documents sent to, received from or prepared by legal counsel should be marked, "CONFIDENTIAL/ATTORNEY-CLIENT PRIVILEGED."

E. Training and Education.

1. Education and Training Required.

The Compliance Committee shall ensure that all Staff Members attend and participate in an initial (new hire orientation) and recurrent education and training programs. Such education and training programs may be tailored to the Organization's needs and the responsibilities of the Staff Members. The Compliance Officer shall, in consultation with the Compliance Committee where appropriate, determine (a) who needs training (both in compliance and in coding and billing), (b) the type of training that best suits the Organization's needs, such as in-service training sessions, outside seminars, or self-study programs utilizing newsletters or other training sources, and (c) the extent to which education and training is needed and how much each person should receive.

2. Implementation.

To implement this Compliance Plan, all Staff Members will be required to participate in orientation (for new Staff Members) and one or more education and training sessions within six months after the adoption of this Compliance Plan. All Staff Members who are engaged by the Organization after the initial implementation of this Compliance Plan will be required to read this Compliance Plan, including the Code of Conduct, within the first thirty (30) days of their engagement with the Organization. The Compliance Plan will be made available to all Staff Members on the Organization's intranet and other locations as communicated by the Compliance Officer. In addition, unless the Compliance Officer makes other arrangements, newly engaged Staff Members will be required to participate in the next regularly scheduled education and training program following their initial engagement with the Organization.

3. Frequency.

The Compliance Officer shall provide or arrange for an education and training program for all Staff Members at such times as determined by the Compliance Officer and Compliance Committee. For all staff involved in billing and coding, and marketing personnel (if any), the education and training shall be at least annually. At the direction of the Compliance Officer or Compliance Committee, other training sessions may be held or otherwise required as the need arises to address changes in this Compliance Plan, in federal or state law or regulation, or in any applicable government or private health care reimbursement programs, or to respond appropriately to any finding of noncompliance.

4. Content and Goals.

The general compliance training sessions should include an overview of this Compliance Plan, the consequences of violating the standards and procedures adopted under this Compliance Plan, and the role of Staff Members in the operation and success of this Compliance Plan. The goals of general compliance training should be to train Staff Members to perform their jobs in compliance with this Compliance Plan and to make clear that compliance is a condition of continued engagement with the Organization. In addition, as deemed appropriate by the Compliance Officer, in consultation with the Compliance Committee when appropriate, training and education sessions may incorporate, among others, any of the following topics: (a) the details and functions of this Compliance Plan; (b) areas of risk exposure identified by the Compliance Committee; (c) claim development and submission processes; (d) marketing practices; and (e) summaries of applicable federal and state laws and regulations and government and private health care reimbursement principles, including, without limitation, fraud and abuse laws, coding requirements, prohibitions against paying or receiving remuneration to induce referrals, prohibitions against self-referrals, proper confirmation of diagnoses, prohibitions against alterations to medical records, the prescribing of medications and procedures without proper authorization, proper documentation of services rendered, and the duty to report any misconduct.

5. Mandatory Participation.

All Staff Members must attend and participate in the Organization's general compliance education and training. Such attendance and participation is a condition precedent to the Staff Member's continued engagement by the Organization.

6. Effect of Non-Participation.

Adherence to the provisions of this Compliance Plan, including, but not limited to, the educational and training requirements, is a factor in the periodic evaluations of Staff Members. Failure to comply with training and education requirements may result in disciplinary action, including possible termination of employment or other engagement.

7. Record Retention.

The Compliance Officer shall retain, on behalf of the Organization, adequate records of the education and training programs. These records may include attendance logs and materials distributed during the training sessions.

F. Effective Lines of Communication.

1. Access to Compliance Officer and Compliance Committee.

The Compliance Officer shall ensure that there are well-publicized open lines of communication between the Organization's Staff Members and the Compliance Officer and CEO. The Compliance Officer shall maintain an "open door" policy under which any individual may discuss compliance issues directly with the Compliance Officer. All Staff Members will be encouraged to report to the Compliance Officer or CEO any incident that is reasonably believed to be noncompliant with federal or state laws or regulations, or government or private health care reimbursement program requirements. All Staff Members will be encouraged to direct any questions about compliance matters to the Compliance Officer. In the absence of the Compliance Officer, reports should be made to the CEO.

2. Method to Report Suspected Noncompliance.

Compliance statements, reports, complaints or questions should be directed to the Compliance Officer or, in the absence of the Compliance Officer, the CEO. Actual or suspected violations of the Code of Conduct or Compliance Plan must be reported by utilizing the Organization's Safe Hotline to report your concerns. You may anonymously call or text Safe Hotline at 1.855.662.SAFE or complete a complaint form at SafeHotline.com/SubmitReport. You must use PCE's Company ID (5681180846) when making your complaint. Suspected noncompliance may also be reported to the Compliance Officer in person or by mail, telephone or email at Compliance_Manager@pcenj.org.

3. Contents of the Statements.

The Compliance Officer shall make known to all Staff Members the information that should be included in a complaint or report of suspected noncompliance. In submitting any

statement alleging noncompliance, the Organization's Staff Members should be guided by the following principles:

- Compliance statements should be based upon facts.
- Compliance statements should contain a brief explanation of the facts giving rise to the concern, the identities of the directors, officers, supervisors, employees or contractors suspected of being involved, the dates upon which the incidents occurred, the subject area or exposure to risk area believed to be violated, and the date the statement is submitted.
- The individual filing a compliance statement may, but need not, include his or her name or any other personally identifiable facts, with the understanding that the ability to fully investigate compliance concerns may be hindered by anonymous reports.

4. Response to Statements.

If the Compliance Officer, in consultation with the Compliance Committee and CEO where appropriate, determines that a statement submitted alleges noncompliance with any federal or state law or regulation, or any third party health care reimbursement program requirement, or this Compliance Plan, the Compliance Committee and the Organization will respond in accordance with the following guidelines:

a. The Compliance Officer, in consultation with the CEO or Compliance Committee, shall determine when and if the Organization's legal counsel should be consulted;

b. If retained, the Organization's legal counsel will be asked to review the statement and advise the Organization as to an appropriate course of conduct;

c. The Compliance Officer, in connection with the Organization's legal counsel when appropriate, shall conduct an internal investigation and report the results of the investigation to the Compliance Committee, Executive Committee and, where appropriate, the Board of Trustees;

d. The Compliance Committee, together with the Compliance Officer and the CEO, in consultation with the Organization's legal counsel as necessary, shall assess the findings and determine the most appropriate response;

e. The appropriate personnel will be notified by the Compliance Officer of the statement, the investigation and the Organization's response, and

f. The Compliance Officer shall appropriately document these activities.

5. Confidentiality/Anonymity/No Reprisals.

Statements alleging non-compliance may be submitted anonymously. When the identity of the complainant is known, the Organization will strive to maintain the confidentiality of the complainant's identity to the extent practicable under the circumstances. The complainant's identity, however, may be disclosed by the Compliance Officer, the Compliance Committee or the Organization, or it may otherwise become known, as necessary for the Compliance Committee and the Organization to respond to the statement. Any Staff Member or contractor of the Organization who files or initiates a complaint or report alleging noncompliance, or any statement concerning operational issues, will not be terminated or subject to any employment action, discipline, reduction in salary, or other retribution, solely as a result of filing any such complaint, report or statement, as long as the reporter filed the complaint, report or statement in good faith and with reasonable foundation in fact.

6. Concurrent Reporting and Analysis.

Staff Members, including billing and coding staff, are obligated under this Compliance Plan to make all reasonable efforts to ascertain billing and claims mistakes or noncompliance before the applicable bill is delivered or the applicable claim is submitted to any third party. Questions concerning the veracity of any bill or claim, or the documentation relating thereto, that arise concurrently with the preparation of a bill or claim must be immediately reported to the Compliance Officer by the individual who discovers the issue, and in all cases the applicable bills and claims must not be delivered or submitted to any third party until the questions are appropriately addressed.

7. Recordkeeping Requirements.

The Compliance Officer, on behalf of the Organization, shall retain in a central file dedicated to compliance matters, copies of: (a) all complaints, reports or other statements; and (b) documentation of the response to the complaints, reports and other statements, including any investigations and corrective actions. The Compliance Officer also shall maintain a log recording the complaints, reports and other statements, and the investigation, and responses arising therefrom, and the monitoring reports made to the Organization, along with the dates of the same.

G. Responding to Detected Offenses and Corrective Actions.

1. Prompt Investigation.

The Compliance Officer shall begin to investigate any complaint or allegation of non-compliance promptly after receiving notice of the complaint or allegation. Upon the commencement of any such investigation, the Compliance Officer shall consult with the Compliance Committee and CEO as needed and, when deemed appropriate, the Organization's legal counsel.

2. Assessing Allegations of Non-Compliance.

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

3. Documentation of Investigation.

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

4. Reporting Violations.

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

H. Enforcement Standards and Disciplinary Guidelines.

1. Acknowledgment.

The Compliance Officer shall require each of the Staff Members to submit to the Compliance Officer a written acknowledgement that he or she has read the Code of Conduct and this Compliance Plan, and that he or she fully understands and agrees to comply with the Code of Conduct, this Compliance Plan and the related standards and procedures. The Compliance Officer may require such acknowledgements on an annual or more frequent basis.

2. Duty to Report.

All Staff Members are obligated under this Compliance Plan to report any and all instances of suspected non-compliance, either directly to the Compliance Officer, or, in the absence of the Compliance Officer, to the CEO, or through any other mechanism made available to the Organization's Staff Members. The failure of any individual to fulfill this obligation will subject the individual to disciplinary action under this Compliance Plan, including termination, in the Organization's sole discretion.

3. Periodic Statements.

The Compliance Officer may require each of the Staff Members to submit, concurrent with the Organization's periodic performance review, a statement as to whether he or she has any knowledge of actual or suspected instances of non-compliance or other wrongdoing, and any recommendations he or she may have for improvement to the overall compliance plan or delivery of quality of care by the Organization. At the discretion of the Compliance Officer, such inquiries may be made, and Staff Members may be required to document their responses, on a more frequent basis, for example, at monthly staff meetings.

4. Disciplinary Actions for Failing to Abide with Compliance Plan.

The Organization may, in accordance with its Employee Manual and other applicable policies, impose varying degrees of disciplinary action against Staff Members who fail to comply with this Compliance Plan or any of the standards and procedures adopted under this Compliance Plan, or any federal or state law, or health care reimbursement program requirement, including, without limitation, warnings, reprimands, probation, demotion, wage reduction, temporary suspension and termination. The Organization also may seek civil damages or, as permitted by law, make a referral for criminal prosecution. The disciplinary actions imposed are at all times within the sole and absolute discretion of the Organization, and such actions may be imposed at any time and in any manner deemed necessary or desirable by the Organization, subject to the terms and conditions of the applicable Staff Member's engagement with the Organization.

5. Guidelines for Discipline.

Without intending to modify any of the terms or conditions of any governing business document or member's agreement, or any Staff Member's engagement with the Organization, and without intending to provide any special rights to its employees and contractors, including its at-will employees, the Organization shall endeavor to impose sanctions or to take other disciplinary actions under this Compliance Plan in a manner that is consistent in respect to the qualifications and the role of the Staff Member involved, and proportionate to the offenses. Toward this end, the Organization may consider the following factors: (1) whether the misconduct was willful, reckless or negligent; (2) whether the Staff Member reported his or her own non-compliance, or it was reported by others; (3) whether the misconduct is an isolated incident or there have been similar reports or incidents; (4) whether or not the Staff Member cooperated fully with the investigation and with any remedial actions required; and (5) the level of liability exposure to the Organization.

6. Exit Interview.

An exit interview may be conducted with each Staff Member who voluntarily resigns. . Exit interviews will not be conducted with Staff Members being otherwise terminated. The interview may be conducted by the Human Resource Department or the Compliance Officer, or his or her designee. The person conducting the exit interview should inquire into whether the individual is aware of or participated in any conduct or activity that could be construed as non-compliant with this Compliance Plan, federal or state law or any governmental or other third party health care reimbursement program requirements. The person conducting the exit interview will document such exit interview, which documentation such person will sign and date and will request that the exiting individual sign and date. The form of Certification is included in the appendices to this Compliance Plan.

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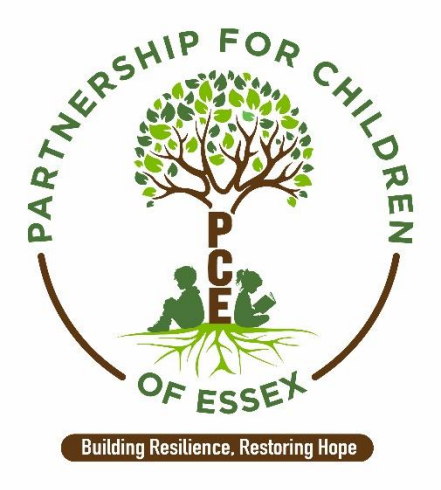

CORPORATE COMPLIANCE PLAN

SECTION IV OF V

REGULATED CONDUCT AND GUIDELINES

IV. REGULATED CONDUCT AND GUIDELINES.

A. Applicability.

Partnership for Children of Essex, Inc. (referred to herein as the "Organization") has instituted policies governing regulated conduct and guidelines as part of its Corporate Compliance Plan.

B. Employee Background Checks; Employee and Vendor Screening.

1. Applicants/New Personnel – Background Checks.

The Compliance Officer shall ensure a process is in place, either by the Compliance Officer or through delegation to appropriate human resources or other personnel or to a vendor/contractor, to make sure a reasonable and prudent background investigation is performed, including a reference check, as a part of the employment or contracting application process for all prospective employees and contractors who will have discretionary authority to make decisions that may involve compliance with the law or compliance oversight. The Organization will not hire or retain any individual who is debarred, excluded or otherwise ineligible for participation in Medicare, Medicaid and other federal and state health care programs. The Compliance Officer, or his or her designee, shall ensure that all applications are thoroughly reviewed and that the databases listed in **Section IV.B.2.**, immediately below, are examined to ensure that the applicant is not listed as debarred, excluded or otherwise ineligible for participation in Medicare, Medicaid and other federal and state health care programs. Reference should be made to the Organization's Background Checks Policy.

2. New and Current Personnel – Exclusion Database Screening.

The Compliance Officer, or his or her designee (including through delegation to human resources or other personnel or to a vendor/contractor), shall ensure that the following databases (as such website addresses may be amended from time to time) are screened for all Staff Members prior to employment and on a monthly basis during the term of employment:

Federal List of Excluded Individuals and Entities (LEIE):

https://exclusions.oig.hhs.gov/

General Services Administration, System for Award Management (SAM):

https://sam.gov/SAM/

State of New Jersey Consolidated Debarment Report:

http://www.nj.gov/comptroller/doc/nj_debarment_list.pdf

If any exclusion database or the website for any exclusion database is changed, the Compliance Officer shall update the Organization's records and practices accordingly.

The list of databases may be expanded as determined by the Compliance Officer or as required by law. Any prospective Staff Members included in any of the aforementioned exclusion lists will not be hired unless the individual can demonstrate, upon reliable and credible evidence, that he or she is not the individual contained in the report, is no longer on the report and provide written proof of same, or has been listed on the report in error and provide written proof of same and that his/her name will be removed. If any Staff Member is found to be listed on any of the aforementioned exclusion lists, the Compliance Officer will perform further research to determine whether the Staff Member is, in fact, the person on the exclusion list, whether the individual should have been removed from the list or was included on the list in error. If the Compliance Officer determines that any Staff Member is included on any of the aforementioned lists, the Compliance Officer immediately will report same to the CEO and Compliance Committee (when deemed appropriate), and seek legal counsel (when deemed appropriate) as to necessary action. If the individual is involved in care management or coding and billing functions, he or she shall be removed from duties until legal counsel is sought.

3. Licensed, Registered and Certified Personnel.

The Compliance Officer, or his or her designee (including through delegation to human resources or other personnel or to a vendor/contractor), shall ensure that all licensure, registration and certification credentials for licensed, registered and certified personnel are verified and in good standing, prior to employment and periodically thereafter on a monthly basis, at the website below and/or other applicable website:

Department of Law & Public Safety, Division of Consumer Affairs:

https://www.njconsumeraffairs.gov/Pages/verfication.aspx

and/or

Department of Health:

https://www.state.nj.us/health/guide/find-select-provider/

4. Vendors.

The Compliance Officer, or his or her designee (including through delegation to the community resources department or other personnel or to a vendor/contractor), shall verify that all vendors engaged with the Organization conduct a reasonable and prudent investigation of its employees, which includes, at a minimum, screening employees against the databases in **Section IV.B.2.** above. The Organization conducts a reasonable and prudent background investigation of all vendors engaged by the Organization, which includes screening the vendor against the database, as follows:

Federal List of Excluded Individuals and Entities (LEIE):

https://exclusions.oig.hhs.gov/

PCE screening of vendor organizations will be performed prior to engagement of the vendor and on an annual basis during the term of engagement. If a vendor is found to be contained on any of the identified exclusion list(s), the Compliance Officer shall seek legal counsel (when appropriate) as to the proper course of action. If the vendor is engaged in care management or billing or coding functions, the vendor shall be relieved of its duties pending legal counsel determination.

Vendor screening of their employees will be verified as part of the MOU process. The Organization shall not execute any contract with or otherwise engage any vendor employing individuals who have been convicted of a criminal offense related to the delivery of health care or who is listed as debarred, excluded or otherwise ineligible for participation in Medicare, Medicaid and other federal and state health care programs.

The Organization provides all vendors with MOUs and/or BAAs access to the Organization's Corporate Compliance Plan on our website and a copy of Federal Deficit Reduction Act of 2005. As a condition of engagement or affiliation, vendors are required to comply with the Organization's Corporate Compliance Plan, including the Code of Conduct, to disseminate the Federal Deficit Reduction Act of 2005 to its employees, and to comply with Section 6032 of the FDRA. Additionally, all approved vendors are required to sign a Business Associates Agreement (BAA) with the Organization.

If a vendor or other contractor is a licensed health care facility, the Compliance Officer, or his or her designee (including through delegation to human resources or other personnel or to a vendor/contractor), shall confirm the licensure status of the vendor or contractor with the applicable licensing authority, e.g., the New Jersey Department of Health or other applicable licensing authority. The New Jersey Department of Health website for searching licensed facilities is below (as may be amended from time to time):

http://www.state.nj.us/health/healthfacilities/about-us/facility-types/

https://www.state.nj.us/health/guide/find-select-provider/

5. Criminal Charges or Proposed Debarment or Exclusion.

In the event that any criminal charge or proposed debarment or exclusion is pending against an individual or entity employed or engaged by the Organization, such individual or entity may be removed from direct responsibility for or involvement with any federal or state health care program. If resolution of the matter results in conviction, debarment or exclusion, the Organization shall terminate the employment or other contractual arrangement with the individual or entity. If the individual is a member of the Board of Trustees a committee thereof, then such individual shall be removed from the Board of Trustees or such committee.

C. Claims Submission and Development.

1. Principles of Coding and Billing.

Under various state and federal laws and regulations, health care providers and others submitting claims for reimbursement to health care programs are subject to civil and

criminal penalties for fraudulent billing practices. There are two fundamental principles of proper billing practice: (i) only submit claims for services actually provided; and (ii) properly document the client record to support the claims submitted. Thus, the Organization must exercise a high level of care in the billing and claims submission process. In this regard, the Organization shall follow the billing and coding rules issued, where applicable, by the Centers for Medicare & Medicaid Services (CMS), state Medicaid programs and other federal and state statutes and regulations, and federal, state or private payer health care program requirements. Furthermore, the Organization's Staff Members must adhere to the following principles:

a. Proper and timely documentation of all professional services must be maintained to ensure that only accurate and properly documented services are billed.

b. Claims may not be submitted for services not performed or for a level of service that exceeds the level of service actually provided.

c. Records and notes used as a basis for a claim submission must be appropriately organized in a legible form so they can be audited and reviewed.

d. All information and services reported on reimbursement claims must be based on medical necessity and must be documented in the client record.

e. The documentation necessary for accurate code assignment must be available to coding staff.

f. The compensation for billing department coders and billing consultants may not provide any financial incentive to upcode or otherwise artificially inflate claims.

g. The Organization either shall appropriately credit a payor or client account, or refund to all third party payors or clients in a timely manner, all revenues to which the Organization is not entitled.

h. Claims will be submitted only for services that are reasonable and necessary.

i. There will be no "double billing" for services.

j. There will be no billing for non-covered services as if covered.

k. There will be no knowing (i.e., with knowledge, deliberate, not accidental) misuse of provider identification numbers and other identification numbers used for claims submission.

l. Billing will be performed in accordance with applicable coding guidelines and there will be no billing for inappropriately unbundled services (i.e., billing for each component of the service instead of billing or using an all-inclusive code).

m. Coding modifiers will be used properly.

n. There will be no upcoding of the level of service provided.

o. There will be no "clustering" of services. Clustering is the practice of coding/charging one or two middle levels of service codes exclusively, under the philosophy that some will be higher, some lower, and the charges will average out over an extended period (in reality, this overcharges some clients while undercharging others).

p. In the event the Organization retains a third party company to perform billing services, the underlying agreement should include the following provisions:

(1) An agreement that the third party will comply with all applicable federal and state laws and regulations;

(2) An agreement to be bound by the terms of this Compliance Plan;

(3) An agreement to notify the Organization in the event that the billing company is under investigation, civil or criminal, regardless of whether the investigation involves the Organization; and

(4) In the event that the billing company has adopted its own corporate compliance program and information is reported internally through such program relating to the Organization, an agreement that such information immediately be reported to the Organization through the Compliance Officer.

2. Care Management/Coding Staff.

a. Communication. The Organization, through the Compliance Officer or his/her designee, shall establish mechanisms for the Organization's coding and billing staff to communicate effectively and accurately with the Organization's care management staff. The Organization shall maintain records of such mechanism, which may include policies and procedures appended to this Compliance Plan. The mechanism should empower the coding and billing staff to adhere to the documentation requirements set forth below and required under applicable law, regulations and payor requirements, and to challenge any failures to satisfy the requirements.

b. Claims Preparation. Coding and billing staff shall submit claims if the appropriate documentation supports the claims and only when such documentation is maintained and available for audit and review. In this regard, coding and billing staff shall comply with and enforce the following policies:

(1) *Documentation*. Coding and billing staff should be familiar with proper record documentation requirements established by the Organization. Documentation created by care management staff must satisfy the requirements before bills or claims are generated.

(2) *Unclear or Illegible Documentation*. If the coding and billing staff finds any documentation to be unclear or conflicting, or illegible, the coding and

billing staff shall seek clarification from the care management staff member prior to submitting any claim. All client records used as a basis for a claim submission shall be appropriately organized in a legible form so they can be audited and reviewed. Supplemental notes, properly dated and identified as supplemental, may be required by the coding and billing staff before submitting claims.

(3) *Diagnosis and Procedures*. The coding and billing staff shall pay particular attention to issues of medical necessity and appropriate diagnosis and treatment codes. The diagnosis or diagnoses, and procedures and other services reported on the reimbursement claim must be based on the client record and other documentation established by care management staff. Documentation necessary to assign the appropriate code must be available to the coding and billing staff at any time.

c. Regular Review of Rejected Claims. The coding and billing staff shall regularly review rejected claims to facilitate a reduction in errors and to determine whether the rejections are part of a larger trend, either due to changes in payor policies or changes in conduct of the Organization. Coding and billing staff are expected to discuss rejections with the care management staff responsible for services, and to raise the issue with the Compliance Officer if a rejection appears to be more than an isolated error or incident.

3. Care Management Staff.

All care management staff involved in care management decisions or documentation shall adhere to the following principles:

a. Documentation. Each care management staff member providing or supervising services provided to a client is responsible for the correct documentation of the services rendered. Appropriate documentation must be placed in the client record and signed by the care management staff member who provided or supervised the services. Care management staff must ensure the pre-authorization has been obtained when necessary before performance of a service.

b. Reasonable and Necessary Services. The necessity and rationale for all services should be appropriately and accurately documented in the client record. Care management staff shall perform only those diagnostic and therapeutic services reasonably believed to be necessary and appropriate for the diagnosis and treatment of the individuals referred for services. However, Medicare, Medicaid and some other insurance plans, will only pay for services that meet the Medicare, Medicaid or other payer, definition of reasonable and necessary. When the Organization bills for services, the bill should be only for those services believed to be reasonable and necessary for the diagnosis and treatment of an individual.

c. Client Records. It is critical that the client record be completed in a timely, accurate and thorough manner. The client record is a reflection of the quality of care given and is essential to providing continuing quality care. There should be appropriate documentation of services provided. Thorough and accurate documentation helps to ensure accurate recording and timely transmission of information. Accurate record documentation should satisfy, at a minimum, the following standards:

(1) All components of the client record should be complete and legible.

(2) The documentation of each client encounter should all relevant information related to services and as needed to ensure proper billing for services rendered.

(3) If not documented, the rationale for ordering or providing therapy or other services should be easily inferred by an independent reviewer or third party who has appropriate training.

(4) Coding reported on insurance claims forms should be supported by documentation in the client record, and the client record should contain all required information. The provider of services must be clearly documented.

d. Claim Forms. Accurate documentation on all forms utilized in care management and billing are important. This includes, but is not limited to, forms used for client encounters, registration, pre-authorizations where applicable, and all other forms completed and retained in client records that may be used to support claims submission. All Staff Members will comply with these requirements. The Organization shall closely monitor the proper completion of all claim forms.

4. Overpayments

If it is determined that a payment received by the Organization constitutes an overpayment from a government-sponsored health care reimbursement program, or an overpayment from a private health care reimbursement program, that is not regularly adjusted by the payor or the Organization (e.g., through set-offs, periodic reconciliations, or other similar processes) as a matter of practice or as specified under a lawfully executed agreement with the private payor, the Organization must return the overpayment to the appropriate program or third party payor promptly as soon as possible after the determination is made. With respect to an overpayment from a government-sponsored health care reimbursement program, the repayment must be made within sixty (60) days after the identification of the overpayment. If any such overpayment is suspected to have arisen from misconduct, or if the circumstances otherwise justify consultation with legal counsel, the Compliance Officer, together with the CEO, shall consult with the Organization's legal counsel in respect to the suspected misconduct and overpayment before taking any other actions.

D. Anti-Kickback Laws and Self-Referral Prohibitions.

1. Illegal Remuneration - Kickbacks.

Individuals and entities are prohibited from soliciting, receiving, offering or paying remuneration of any kind (e.g., money, goods, services), directly or indirectly, in return for or to induce a referral or recommendation, or for purchasing, leasing, ordering, or arranging, for any, health care items or services. Accordingly, whenever the Organization intends to enter into a business arrangement with any person or entity from which or to which the Organization receives or makes referrals, the Organization will first assess the relationship's compliance with federal and

state anti-kickback laws, rules and regulations, and any available safe harbors. This includes the federal Anti-Kickback Statute (42 USC § 1320a-7b(b)) and state laws prohibiting kickbacks.

There are many transactions that may violate the anti-kickback rules. For example, no one acting on behalf of the Organization may offer gifts, loans, rebates, services, or payment of any kind to a physician that refers clients to the Organization, or to a client or family member, without consulting the Compliance Officer who may consult with legal counsel. Any discounts offered by suppliers and vendors, as well as discounts offered to third party payors, should first be reviewed by the Compliance Officer and/or legal counsel. Rentals of space and equipment must be at fair market value, without regard to the volume or value of referrals that may be received in connection with the space or equipment. Fair market value should be determined through an independent appraisal.

Agreements for professional services, management services, and consulting services must be in writing and have specified terms to include compensation that is set in advance and at fair market value. Payment based on a percentage of revenue should be avoided in many circumstances. Any questions about these arrangements should be directed to the Compliance Officer, who may consult with legal counsel.

The U.S. Department of Health & Human Services has described a number of payment practices that will not be subjected to criminal prosecution under the federal Anti-Kickback Statute. These so-called "safe harbors" are intended to help providers protect against abusive payment practices while permitting legitimate ones. If an arrangement fits "squarely within" a safe harbor, it will not create a risk of criminal penalties including exclusion from the Medicare and Medicaid programs. However, the failure to satisfy every element of a safe harbor does not in itself make an arrangement illegal. Analysis of a payment practice under the law and the safe harbors is complex, and depends upon the specific facts and circumstances of each case. The Organization's Staff Members should not make their own judgments on the availability of a safe harbor for a payment practice, investment, discount, or other arrangement. These situations must be reviewed with the Compliance Officer, who may consult with legal counsel.

Violation of the federal Anti-Kickback Statute is a felony, punishable by significant monetary penalties or imprisonment, or both. Violation of the law could also mean that an entity and/or a provider becomes excluded from participating in the Medicare and Medicaid programs, and other federal health care programs.

2. Inducements.

The anti-kickback laws referred to in the preceding section also prohibit health care providers from inappropriately inducing individuals to use particular services. Examples of such inducements may include routinely waiving coinsurance or deductible amounts without a good faith determination and documenting that the individuals are in financial need, or failing to make reasonable efforts to collect any such cost-sharing amounts. Accordingly, whenever the Organization intends to market services or otherwise provide incentives for individuals to use a particular service, it will first assess the intended marketing plan or incentives for compliance with this Compliance Plan and applicable law.

3. Self-Referrals.

Under federal and state laws prohibiting self referrals, health care providers are prohibited from referring individuals to an entity with which the provider, or an immediate family member of the provider, has a "financial relationship," unless a specific statutory or regulatory exception exists. At the federal level, the self-referral law is known as the Stark Law, 42 USC § 1395nn. The term "financial relationship" is interpreted liberally by federal and state regulators and includes ownership or investment interests through equity, debt or other means, and also compensation arrangements. Thus, the Organization must use caution in referral relationships with physicians who have a financial relationship with the Organization, even through a contractual relationship.

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

Federal and state anti-fraud and false claims laws prohibit, among other things, the "knowing" presentation of false or fraudulent claims for payment to federal and state health care programs. Details regarding these laws are contained in the Organization's Federal Deficit Reduction Act Policy in **Section V** of this Compliance plan.

F. Government Investigations.

The federal and state governments have made the investigation and prosecution of health care fraud one of their highest priorities and have proposed many initiatives for identifying fraudulent practices. Consistent with that emphasis, it is the aim of the Organization to take all reasonable steps to prevent or eliminate any improper activities. In the event that the Organization is the subject of a government inquiry or investigation, the Organization's policy has been and will continue to be to provide cooperation to government authorities while at the same time protecting the rights of the Organization and its Staff Members. The purpose of this policy is to provide a uniform method for the Organization's Staff Members to respond to any government inquiry.

1. Definition of "Federal and State Government Agency."

For purposes of this policy, a government agency includes, but is not limited to, the organizations listed below. If you are contacted by an organization that is not on this list and you are unsure whether the organization is a federal or state government agency, you should immediately contact the Compliance Officer or CEO.

United States Department of Justice	The federal enforcement agency responsible for civil and criminal prosecutions of all federal laws.
Office of the Inspector General	Investigative arm of federal government programs, under the Department of Health and Human Services.
Federal Bureau of Investigation	Investigative arm of federal government programs.

Medicaid Fraud Control Unit (MFCU)	The investigative arm of state Medicaid agencies.
Centers for Medicare and Medicaid Services (CMS)	The federal agency overseeing the administration of the Medicare and Medicaid programs.
Medicaid Programs	State health insurance programs for the indigent. In New Jersey, the agency overseeing the New Jersey Medicaid programs is the Department of Human Services, Division of Medical Assistance & Health Services
Department of Health and Human Services, Drug Enforcement Agency (DEA)	The federal agency overseeing the administration of controlled substances.
NJ Attorney General's Office	The arm of state government responsible for investigation and prosecution of state law violations.
NJ Board of Medical Examiners (BME)	State authority responsible for investigating professional discipline issues involving physicians. Other professional licensing boards oversee other professional disciplines, including, for example, the New Jersey Board of Nursing, New Jersey State Board of Psychological Examiners and the New Jersey State Board of Social Work Examiners.
Department of Labor, Occupational Safety and Health Administration (OSHA)	The federal agency charged with enforcement of safety and health laws and regulations.
Department of Health and Human Services, Office for Civil Rights	The federal agency responsible for investigating violations of HIPAA privacy standards and violations of civil rights laws.

2. Procedures for Visits from Government Agencies.

While it is the Organization's policy to cooperate during an investigation or inquiry, the Organization follows these procedures to obtain full information regarding the scope of the investigation or inquiry. When a representative of a federal or state government agency contacts a Staff member anywhere, such as at home or at the office, for information regarding the Organization or any other entity with which the Organization does business, the Staff Member should do the following:

a. Check ID. If the government representative appears in person, ask to see his or her identification and business card. Otherwise, ask for the person's name and office, address and telephone number, identification number and call the government representative's office to confirm his or her authority. If more than one government representative appears, there will often be one government representative in charge. The Staff Member should determine who this government representative is and ask that government representative to provide the information. Document and retain the agents' names, titles, divisions, badge numbers, addresses and telephone numbers.

b. Check for Search Warrant or Other Documentation. If the government representative wants to search offices of the Organization or obtain any documents from the Organization, including any client records, ask to see a legal document authorizing the search, such as a search warrant and any affidavit supporting the warrant or a court order, and request a brief time to consult with the Compliance Officer or CEO. The Compliance Officer or CEO should consult with legal counsel regarding the legal documents presented. Many searches are not permissible without a valid search warrant, but certain agencies, such as OSHA, the Medicaid Fraud Control Unit, the Office of Inspector General and the Medicaid Programs, may seek access and may assess penalties for failure to provide access upon reasonable request. Make a copy of the legal documentation presented by the representative. Note that a valid search warrant should include the names and types of law enforcement agents allowed to conduct the search, the Organization's name and address, the date and time that the search is permitted, and a description of the part of the Organization's offices, records and property the agents are permitted to search.

c. Contact the Organization's Leadership. If contacted by a government representative, immediately notify a supervisor, the Compliance Officer and the CEO, and relay all information and documentation you gathered from the agent. Either the Compliance Officer or the CEO will provide instructions on how to proceed. If a government agent visits in person to search any offices or records of the Organization, the Staff Member should request a delay until he or she has consulted with the Compliance Officer or the CEO, and as authorized, the Organization's legal counsel.

d. Conduct During a Search. During any search of the Organization's offices or records, remember the following:

(1) *Be Courteous*. Be courteous and helpful while following all guidelines provided by the Organization. Do not forget to check identifications, or to seek documentation of authority, and to request time to consult with the Compliance Officer or the CEO.

(2) *Observe*. Remain on the premises, observe the search, and take detailed notes until a supervisor, the CEO, the Compliance Officer, or legal counsel for the Organization arrives. Do not leave the government representative alone while he or she searches the premises, but do not interfere or obstruct a valid search.

(3) *Keep Detailed Notes*. Keep detailed notes of everything that the government representative requests, inspects (whether or not they are seized), or seizes, and detailed notes of any conversations that may be held with a government representative.

(4) *Make Copies*. Request a receipt for all documents that the government representative copies, including the number of pages copied. If the government representative wishes to seize original documents, ask for those documents to be copied first. If permission is not granted to make copies, make a list of all documents before they are removed from the premises.

(5) *Computers*. If the government representative wants to seize computers, ask to copy all files to a disk or other backup media.

(6) *Questions from Representatives*. Staff Members are required to answer questions concerning the location of documents, but are not required to answer questions regarding the contents of the documents. A Staff Member may tell the representative that he or she prefers to wait until the Compliance Officer, the CEO or the Organization's legal counsel is present.

(7) *Affidavits*. Staff Members are not required to comment on the validity of any affidavit presented, nor are they required to sign any document prior to review by legal counsel.

3. Interviews.

a. Interviews or "Conversations". If the government representative wants to speak with you personally, then find out why without getting into details. It is not unusual for government representatives to lead you to believe that you must speak to them when they first contact you, or to imply that it is wrong for you to refuse to speak with them during this first contact, or to suggest that your best interests would be served by speaking to them immediately when contacted. Remember, you are not required by law to respond immediately to such inquiries; you are permitted to schedule an appointment to speak with them at a different time, and you are entitled to have someone with you during any interview.

b. You Are Free to Speak. If you wish, you are free to speak with the government representative. If you choose to be interviewed by a government representative before calling the Compliance Officer or the CEO, you should contact the Compliance Officer and the CEO as soon as possible after the interview. Remember that you may also have someone of your choosing present during the interview with the government representative. You are encouraged to take notes during the interview, or as soon thereafter so that you may document the encounter.

c. Legal Representation. You are entitled to have someone with you during any interview with a government representative and you should request that the Compliance Officer, the CEO or legal counsel be present. The Organization will arrange to have its legal counsel present at no cost to you or, if you wish, you may consult with an attorney of your own choosing at your expense.

d. Interview Guidelines. During any interview with a government representative, you should follow these simple guidelines:

(1) Always tell the truth. If you do not recall something or have no knowledge about the topic that the government representative is asking about, say so.

(2) Be very careful to answer questions completely, accurately and concisely so that there will be no misunderstanding as to what you are saying. It is important to make clear to the government representative whether the information that you are providing is first-hand knowledge, something you have heard, or speculation. It is good practice to avoid speculation, but if you do speculate, it is important to make sure you let the government representative know that you are speculating.

(3) If you have not already done so, please contact the Compliance Officer and the CEO as soon as possible after the interview.

4. Inquiries by Mail.

If you receive a request in the mail from a government representative for documents or a subpoena, immediately provide a copy to the Compliance Officer. Do not respond to the request until receiving instructions from the Compliance Officer.

5. Post-Investigation.

a. Communications Regarding an Investigation. Do not discuss an investigation with anyone without first receiving permission from the Compliance Officer or CEO. All inquiries concerning an investigation, including from any media representative or any other Staff Member, should be referred to the Compliance Officer or CEO.

b. Document Preservation. Do not alter or destroy documents (whether paper, electronic or email). Once the Organization has notice of an investigation, no Organization personnel may alter, throw away or destroy records or other documents.

c. Communications with Counsel. Once a government contact is initiated, establish a specific file for communications to and from legal counsel. Caption the file and all of your memoranda, notes or other communications with legal counsel with the words "CONFIDENTIAL ATTORNEY-CLIENT PRIVILEGED COMMUNICATION." Do not make copies other than a file copy, and do not further distribute any of the confidential communications with legal counsel. Distribution may destroy the privilege of confidentiality.

G. Retention of Compliance Records.

1. Compliance Records.

All records necessary to protect the integrity of the Organization's compliance process and to confirm the effectiveness of the Compliance Plan will be maintained on-site in accordance with applicable law. These records should be maintained and preserved on a confidential basis, such that access is limited to those who require access to perform their duties on behalf of the Compliance Committee or the Organization. Certain records, marked "CONFIDENTIAL/ATTORNEY-CLIENT PRIVILEGED" will be maintained separately and will not be copied or distributed except in consultation with legal counsel.

The kinds of records the Organization will maintain include the records listed below. This is not an exhaustive list, but it serves to underscore the importance of retaining compliance records and it provides a guideline for the Compliance Committee.

a. All records and documentation (e.g., client records and billing and claims documentation) required either by federal or state law for participation in federal healthcare programs or any other applicable federal and state laws and regulations.

b. Copies of the Compliance Plan, as adopted and as amended from time to time.

c. List of Compliance Committee members, including the names and ordinary job titles and responsibilities of such individuals and the periods such individuals served on the committee.

d. Information on the Compliance Officer, including name, contact information and term of office.

e. Documentation of compliance training and education efforts, including acknowledgments from Staff Members of their review and understanding of the Code of Conduct and, as applicable, this Compliance Plan, and documentation of attendance at training sessions.

f. Documentation of audits conducted, including the findings and any corrective actions taken, and reports prepared regarding same.

g. Compliance Committee reports to the members.

h. Compliance complaints and investigations, findings and corrective actions.

i. Results of exit interviews and any periodic statements collected from members, employees or contractors concerning the Organization's health care reimbursement compliance.

j. Any self-disclosure and refund made to a government or third party payor.

k. Background checks on vendors, contractors and Staff Members.

l. Identification of and agreements with any outside auditors and legal counsel.

2. Third Party Payor Communications.

If any Staff Member has questions or concerns about ambiguous or confusing reimbursement rules, such Staff Member may contact the government or private third party payors to obtain clarification. Any advice received from such a third party payor with respect to coding

and billing should be documented in writing. Any advice received verbally should be confirmed in writing by a letter from the Staff Member to the payor restating the basis of the inquiry, the answer received, and a notification that the payor should contact the Organization immediately in the event the advice has been misinterpreted. All such communications with third party payors should be stored with the health care reimbursement compliance records. As applicable, such communication should also be filed with the applicable client's records.

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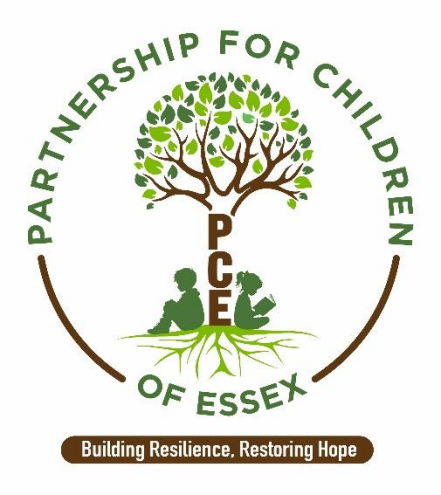

CORPORATE COMPLIANCE PLAN

SECTION V OF V

FEDERAL DEFICIT REDUCTION ACT POLICY

V. FEDERAL DEFICIT REDUCTION ACT POLICY

A. Introduction.

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

B. Applicability.

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

C. Section 6032 of the Deficit Reduction Act of 2005, 42 U.S.C.§1396a(d) (68)

Section 6032 of the Deficit Reduction Act of 2005 requires entities that received or made payment of $5 million or more (aggregate) in Title XIX funds during the previous fiscal year (ex: Oct. 1, 2021 – September 2022) to assist in preventing, detecting and addressing fraud, waste and abuse in federal health care programs by taking certain actions, including:

- Establishing written policies for employees, contactors and agents that provide detailed information about federal and state false claims statues and penalties, and whistleblower protections.
- Educating employees, contractors and agents on the policies and procedures for detecting and preventing fraud, waste and abuse.
- Providing information in the employee handbook, if one exists, about federal and state false claims, statutes, penalties, and whistleblower protections.

Those laws are summarized below.

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

1. Federal Anti-Fraud And False Claims Laws.

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

The FCA is a law that prohibits a person or entity, such as the Organization and its Staff Members, agents and contractors, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the federal government. The FCA also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or

paid and knowingly or improperly retaining an overpayment. These prohibitions extend to claims submitted to federal and federally-funded health care programs, such as Medicare and Medicaid.

The FCA broadly defines "knowing" and "knowingly." Knowledge will have been proven under the FCA if the person or entity: (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information. The law specifically provides that a specific intent to defraud is not required to prove a violation.

A person or entity found guilty of violating this law will be liable for civil money penalties. From time to time, the Department of Justice has adjusted these penalties to reflect the rate of inflation and as such, they vary depending on the date the penalty was assessed or the violation occurred. As of July 3, 2025, the civil money penalties may range from $14,308.00 to $28,619.00, with potential periodic inflation adjustments. (FCA)

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

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

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

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

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

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

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

Violation of the PFCRA may include civil money penalties. From time to time, the Department of Justice has adjusted these penalties to reflect the rate of inflation and as such, they vary depending on the date the penalty was assessed or the violation occurred. As of July 3, 2025, the civil money penalties equal $14,308.00 per claim or statement in violation of the PFCRA, with potential periodic inflation adjustments, as well as potential assessments for claims paid by the federal government.

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

a. The New Jersey False Claims Act, _New Jersey False Claims Act, N.J.S. 2A:32C-1 et seq

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

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

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

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

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

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

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

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

The NJIFPA makes it unlawful to (i) present or cause to be presented (including the assisting, conspiring or urging of another to present) any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy knowing the statement contains false or misleading information concerning any

fact or thing material to the claim, or (ii) conceal or knowingly fail to disclose the occurrence of an event which effects any person's initial or continued right or entitlement to any insurance benefit or payment or the amount of any benefit or payment to which the person is entitled. A violation of this law can subject a person or entity to civil damages equal to three times the amount of damages, tiered money penalties based upon the number of offenses, and a State surcharge. In addition, the law authorizes the State Attorney General to pursue additional criminal penalties.

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

Provisions in this comprehensive law allow for the imposition of criminal fines and terms of imprisonment for various violations involving the submission of claims for payment under the Medical Assistance Program. For instance, such criminal penalties may be imposed upon a health care provider who willfully receives Medical Assistance payments to which the provider is either not entitled or that are in a greater amount than that to which the provider is entitled. The law also allows penalties to be imposed upon an individual or entity that (i) knowingly and willfully makes or causes to be made any false statement or false representation of a material fact in any claim form in order to receive payment, (ii) knowingly and willfully makes or causes to be made any written or oral false statement for use in determining such payment, or (iii) conceals or fails to disclose the occurrence of an event which affects the right to receive such a payment. Penalties may also be imposed if false statements or representations of a material fact are made in connection with the conditions or operations of any institution during an initial or recertification process entitling the facility to payments under the Medical Assistance Program. Under the MAHSA, it is also unlawful for an individual or entity to solicit, offer or receive a kickback, rebate or bribe in connection with the furnishing of items or services for which payment is made or the furnishing of items or services whose cost is or may be reported to obtain benefits or payments under Medical Assistance Program. In addition to criminal fines and jail sentences, violators of this law are also subject to civil penalties, which can include treble damages, interest on the overpayments, and not less than and not more than the civil penalty allowed under the federal FCA for each false claim submitted.

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

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

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

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

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

f. False Claim for Payment of a Government Contract.

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

g. Whistleblower Protections.

Under the New Jersey Conscientious Employee Protection Act (CEPA), N.J.S.A. § 34:19-1 et seq., employers are prevented from taking any retaliatory action against an employee who discloses (or threatens to disclose) to a supervisor or to a public body any activity, policy or practice of the employer that the employee reasonably believes is fraudulent or criminal and that may defraud an individual or governmental entity, among others. In addition, the law protects employees who object or refuse to participate in such activity, policy or practice. Specific protection is also given to licensed or certified health care professionals who object to or refuse to participate in any activity, policy or practice that the employee reasonably believes constitutes improper quality of care.

E. Other Fraud and Abuse Laws.

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

F. Procedures for Detecting Fraud, Waste and Abuse.

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

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

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

Any questions regarding the Organization's Compliance Plan, including the Code of Conduct, should be directed to the Compliance Officer or, in the absence of the Compliance Officer, the CEO. Actual or suspected violations of the Code of Conduct or Compliance Plan must be reported by utilizing the Organization's Safe Hotline to report your concerns. You may anonymously call or text Safe Hotline at 1.855.662.SAFE or complete a complaint form at SafeHotline.com/SubmitReport. You must use PCE's Company ID (5681180846) when making your complaint. Reports may also be made to the Compliance Officer in person or by mail, telephone or email at Compliance_Manager@pcenj.org.

Potential or actual fraud, waste and abuse involving the Medicaid program also may be reported through the Medicaid Fraud Division Hotline: 888-937-2835 or https://www.nj.gov/comptroller/about/work/medicaid/complaint.shtml. Potential or actual fraud, waste and abuse involving any insurance program also may be reported to the New Jersey Insurance Fraud Prosecutor Hotline: 877-55-FRAUD (877-553-7283) or https/njinsurancefraud2.org/#report.

G. Non-Retaliation.

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

H. Distribution and Acknowledgement.

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

I. Annual Certification.

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

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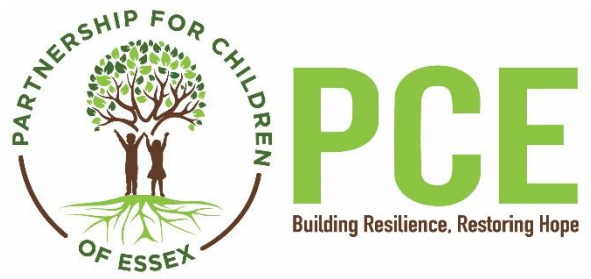

CORPORATE COMPLIANCE PLAN

APPENDICES

APPENDICES

1. Resolution regarding the Corporate Compliance Plan
2. Form Confidentiality Agreement for Compliance Committee Members
3. Acknowledgement Form
4. Exit Interview Certification Form
5. Corporate Compliance Billing Audit Plan

PARTNERSHIP FOR CHILDREN OF ESSEX, INC.

BOARD RESOLUTION REGARDING CORPORATE COMPLIANCE PLAN

Amendments Adopted: July 9, 2021

The Board of Trustees of **Partnership for Children of Essex, Inc.** (the "Organization") does hereby adopt the following preamble and resolutions, and consents to action taken by virtue thereof, as of this ____ day of February, 2020.

WHEREAS, an effective internal control system promoting adherence to and compliance with applicable federal and state law and regulations, and the program requirements of federal, state and private health plans, is consistent with the Organization's goal of billing and claims integrity and compliance; and

WHEREAS, the Organization adopted and implemented, over a period of years, various policies and procedures comprising its compliance program; and

WHEREAS, the Organization adopted and implemented an updated comprehensive corporate compliance plan (the "Compliance Plan") in April 2017 consistent with guidance published by the Department of Health & Human Services, Office of Inspector General and other guidance; and

WHEREAS, in order to maintain the Compliance Plan in accordance with regulatory and other changes, the Organization has amended the Compliance Plan effective as of the date hereof.

NOW, THEREFORE, IT IS HEREBY RESOLVED that the amended Compliance Plan dated February _____, 2020 as distributed to the Board of Trustees, is adopted as presented; and

IT IS FURTHER RESOLVED that a copy of this resolution be attached to the amended Compliance Plan as an exhibit; and

IT IS FURTHER RESOLVED that the Compliance Officer and Compliance Committee continue to be authorized to oversee the implementation, maintenance, and periodic review and amendment of the Compliance Plan, and to further the purposes of the Compliance Plan, that the Compliance Committee be, and is hereby, authorized to oversee the development, revision and enforcement of any supplemental compliance guidance it may determine is necessary or desirable.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the undersigned has executed this Board Resolution Regarding Corporate Compliance Plan as of the date set forth above.

PARTNERSHIP FOR CHILDREN OF ESSEX, INC.	**ATTEST**
By: _____	By: _____
Name: Carmine Guinta	Name: Victor Alvarez
Title: President, Board of Trustees	Title: CEO

CONFIDENTIALITY AGREEMENT
FOR COMPLIANCE COMMITTEE MEMBERS

THIS CONFIDENTIALITY AGREEMENT ("Agreement"), entered into as of the date set forth on the signature page below, is by and between:

Partnership for Children of Essex, Inc. (the "Organization")

and

_____
Name

_____
Address

_____
(the "Member").

RECITALS

WHEREAS, the Organization has developed and implemented a Corporate Compliance Plan (the "Compliance Plan"), and has appointed Member to serve as a member of the Organization's Compliance Committee;

WHEREAS, Member has accepted the appointment of the Compliance Committee, and Member understands all of the duties and obligations of such position, including, without limitation, the duties and obligations set forth under the Compliance Plan;

WHEREAS, in accordance with the Compliance Plan, Member may have access to, receive, collect or otherwise obtain, or create information regarding the Organization's operations or its conduct under the Compliance Plan that is not available to staff members or the general public; and

WHEREAS, the parties desire to protect the confidential nature of such information.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. For purposes of this Agreement, the term "Confidential Information" means all proprietary business information, client records and information and data pertaining in any way to the Organization, including, but not limited to, information and data relating to compliance activities or to the maintenance or administration of the Compliance Plan.

2. Member will not disclose any Confidential Information to any third party (including, but not limited to, federal and state governmental entities or their agents) without the prior written consent of the Organization, and Member will not use any Confidential Information

for Member's own benefit or the benefit of any other individual or entity at any time except as authorized in advance and in writing by the Organization.

3. If Member is requested or required to disclose any Confidential Information by a third party, including by court order, subpoena or other legal request, Member will provide the Organization with prompt notice of any such request or requirement prior to disclosing such information, unless such notice is prohibited by law, so that the Organization may seek an appropriate protective order, or otherwise waive compliance with the provisions of this Agreement. Nothing in this Agreement is intended to limit or prohibit Member from testifying truthfully in any forum.

The parties have executed this Agreement on the date set opposite the signature of the Organization's authorized representative.

PARTNERSHIP FOR CHILDREN OF ESSEX, INC.	**MEMBER**
By: _____	_____
Name:	Name:
Title:	
Date: _____	Date: _____

PARTNERSHIP FOR CHILDREN OF ESSEX, INC.

ACKNOWLEDGEMENT FORM
CODE OF CONDUCT AND COMPLIANCE PLAN

The undersigned does hereby affirm and certify that:

1. I have received (directly or through access to the Organization's intranet), read, and understand the Code of Conduct, and I have received (directly or through access to the Organizations intranet), read and understand the Corporate Compliance Plan (the "Compliance Plan") of **Partnership for Children of Essex, Inc.** ("Organization"), including Section V of the Compliance Plan, regarding Section 6032 of the federal Deficit Reduction Act of 2005. I will abide by the Code of Conduct and the Compliance Plan. I have received educational training with regard to the Code of Conduct and the Compliance Plan, and compliance issues in general as they affect my role in the Organization. I understand the disciplinary policies of the Organization with regard to individuals who violate laws, regulations, standards, and operating policies.

2. I realize that I have an obligation to report actual or suspected misconduct that may violate the Code of Conduct or the Compliance Plan along with actual or suspected violations of laws, regulations, and standards that I may observe in the Organization. I recognize that concerns should be forwarded to the Compliance Officer or Compliance Committee, along with any evidence or proof of misconduct that may assist in an internal investigation. I will make all reports in good faith, based on reasonable and credible information.

3. I understand that I have the right to ask to remain anonymous in any report filed with the Compliance Committee, but I also recognize I may need to reveal my identity if necessary to fully investigate the compliance issue. I also recognize that in the event an investigation by federal or state authorities is conducted, those authorities may require me to serve as a witness and that, in such an event, I may no longer maintain anonymity.

4. I understand that if I am named to any list of individuals excluded or debarred from participation in federal or state reimbursement programs, my employment or other engagement with the Organization may be terminated.

_____
[Signature]

_____
[Print Name]

_____
[Job Title]

Date:_____

PARTNERSHIP FOR CHILDREN OF ESSEX, INC.

EXIT INTERVIEW
CERTIFICATION FORM CONCERNING COMPLIANCE

The undersigned does hereby certify that:

1. I am familiar with the Corporate Compliance Plan (the "Compliance Plan") and the Code of Conduct included in the Compliance Plan of **Partnership for Children of Essex, Inc.** (collectively, "Organization").

2 Except as set forth below, I am not aware of any violations of the Compliance Plan, the Code of Conduct, or any laws, regulations, rules, policies or procedures applicable to the Organization that have occurred during the term of my employment or engagement with the Organization. If none, write "none" below, but the same will be assumed if the below is blank.

_____

_____

_____

_____

3. I agree to meet with the Compliance Officer and Compliance Committee, if so requested, at a reasonable time to discuss the information provided above.

4. If I become aware of any violations or possible violations after signing this certification form, I shall report that information to the Compliance Officer or other member of the Compliance Committee identified by the Organization for such purposes immediately upon learning of the violation or possible violation.

5. I understand and agree that, in lieu of completing the information required by Section 2 above, I have a duty to meet with the Compliance Officer or another member of the Compliance Committee to discuss my reasons for not completing this certification, and any information that is required by it.

_____ Date: _____
[Signature]

_____
[Print Name]

Witness: _____ Printed Name: _____

FY' 2024-25
Corporate Compliance Billing Audit Plan

Introduction:

I. Corporate Compliance Requirement for a Baseline Audit:

"The Organization *may* cause to be conducted a baseline claims submission audit following the implementation of this Compliance Plan. This baseline audit should examine the claim development and submission process, from client intake through claim submission and payment, and identify elements within the process that may contribute to non-compliance or that may need to be the focus for improving execution. This baseline audit should establish a methodology for selecting and examining client records, which may serve as the continuing methodology for future claims submission audits." (PCE Corporate Compliance Manual pg. 6, 4 b.)

II. PCE Plans for Baseline Audit:

As a beginning point, a general baseline audit of our current billing practices was performed in the third quarter (July-Sept.) of the 2021 calendar year. Based on the findings of this audit, planned periodic audits were established and unscheduled audits conducted if the need arose. The scope of these audits was periodically modified based on the findings of the previous audits to ensure that the audits are focusing more specifically on any areas of concern that might be identified. The basic methodology established for selecting and examining records for the baseline audit will be used for all subsequent periodic audits unless reasonable adjustments are needed to address deficiencies discovered in the audit process or circumstances change. Methodology for selecting and examining records for unscheduled audits due to issues that arise may require adjustment to ensure we are addressing the concern.

III. Proposed Audit

A. Purpose of Audits: Coding and Billing audits have been established to ensure PCE's billing and coding compliance and to identify areas of concern that might contribute to Medicaid waste, fraud or abuse.

B. Goals: The goals of the audit are to address the following questions:

1. Was a plan submission note present?
2. Was the youth eligible for Medicaid billing submission?
3. Did the youth have an active eligible authorization?
4. Were progress notes present and demonstrate quality care management?
5. Were the progress notes written during the required time frame?
6. Was the Medicaid billing submitted accurately coded and accurately reflect services provided?

7. Were the services provided "medically" necessary?
8. Were there any incentives for the provision of unnecessary services or items?
9. Was the youth transitioned at the beginning of the month subsequent to the conclusion of services?

Based on data analysis of previous audits and emerging concerns identified during the past three years, additional categories of examination have been added in FY 24 -25. The following questions will also be examined during FY 24-25:

10. When back billing occurred, what was the reason?
11. When claims loss occurred due to the expiration of the Medicaid billing window, what were the causes.

C. Frequency: Audits will be conducted quarterly during the fiscal year. The table below shows the proposed frequency and quarters to be examined. The period of time between the close of the quarter and conducting the audit allows for the majority of billing to have been paid for services provided during that quarter.

Month/Year when audit will take place:	**Records will be reviewed from this period:**	**Lost Claims Report Due to QA**	**Reports written:**
Nov.	1st Quarter (July – Sept.)	Oct. 31	Dec. - Quarterly Report
February	2nd Quarter (Oct. -Dec.)	Jan. 31	March – Quarterly Report
May	3rd Quarter (entire year)	May 31	June – Quarterly Report
August	4th Quarter (April – June)	July 31	Sept. – Quarterly Report/ Annual Report

D. Responsible Parties: Audits will be conducted internally by the PCE Quality Assurance Department, Medicaid Biller and Corporate Compliance Officer with assistance from Operations staff when required.

E. Type of Reviews: Reviews will be conducted of a "random" selection of records within categories reflecting a representative sample of PCE's population served. Records will be pulled from 4 different "categories": Records of New Admissions (30 days), Records open 90 days or Longer, Records of Transitioned Youths, Records for Back Billing.

Based on issues raised during previous audits, the additional query was added:

- What are the specific causes of nonpayment in cases where the Medicaid billing window has expired?

This question will require the review of all records identified during each quarter that a lacked an accurate billing criterion when they were deemed billable for the month or in nonpayment from Medicaid as a result of the billing window having expired.

F. Scope of Audit: The audit will be "retrospective," reviewing records after claims submission to Medicaid, as well as any of those which were not submitted in a timely manner resulting in nonpayment. **Sample Size: For FY 2024-25,** a total of approximately 25% of records for all youth served annually will be pulled for the audits, with 25% of that total examined during each audit period. The annual review of 25% of records will provide PCE with a legitimate sample size for the coding and billing audit. Based on a FY 2024-25 estimated annual census of approximately 1500 records, 360 records will be pulled: 90 in each quarter.

The number of records to be pulled and examined each fiscal year is based on an estimation of the number of youth that will be served during that period of time. However, this formula does not include those records which will be examined due to not being submitted to Medicaid in a timely manner resulting in nonpayment. In that data set, all records that meet this criteria during the quarter will be reviewed.

Of the 90 records pulled in each quarter, the audits will include the following number of records from each of the 4 categories:

- **New Admissions:** 22 records - In this category, only records of youth who have received services for no more than 30 days will be reviewed in entirety for questions 1-4 and 8-9 as identified in Section B: Goals.
- **Records open for 90 days or longer:** 22 records in this category will be reviewed in entirety to ensure that there was an Active Authorization at the time of the review, regardless of the period of time covered by the authorization, as well as reviewing them for questions 1- 4 and 8-9 as identified in Section B:Goals In the initial 2021 Coding and Billing Plan, records in this category were to be examined for 60 Day Authorizations. However, since authorizations are not consistently written to cover a period of 60 days but are written for a range of different time periods, the audit plan was adjusted to address this issue.
- **Transitioned Youth**: 23 records -records in this category will be reviewed in entirety for questions 1-5 and 8-9 as identified in Section B: Goals.
- **Records for Back Billing**: 23 records (these records will only be pulled from months 1 and 2 from each quarter due to the timing of PCE billing practices) and will be reviewed for questions 1- 6 and 8-9 in Section B: Goals.
- **Records where the Medicaid billing window has expired**: All records identified during each quarter where lack of billing resulted in lost claims will be examined for question 7 in Section B: Goals. Based on these criteria, the number of records examined for lost claims will vary from quarter to quarter.

Based on the findings of the FY 24-25 audit, additional goals may be added or substituted in future audits. These goals might include issues such as:

1. Specific risk areas identified by PCE, including documentation of "medical" necessity, confirmation that all services ordered were actually performed and documented and that only those services were billed.
2. A review of codes and modifiers assigned to claims.

3. Discovery of data entry errors.

G. Response to Problems: Compliance challenges identified during any audit conducted, such as coding and billing, will promptly be evaluated and addressed. If appropriate, the evaluation and proposed solution will be made in consultation with PCE's advisors, including legal counsel. Potential solutions to identified problems may include actions such as modification of PCE's standards, policies and procedures, additional training and education for staff, and, if warranted, notice and return of overpayment or re-submission of corrected claims.

H. Audit Process and Timeframes: From time to time, PCE, in conjunction with its advisors, including legal counsel, if necessary, will review the auditing process plan to ensure that it best suits the subjects and goals of the audit.

The timeline for the audit will be as follows:

Time Frame	**Task**	**Responsible staff**
Week 1-3	Pull the records in numbers and categories identified in the Sample Size section of this document.	QA Staff
Week 1-3	Review records to determine if billing related to the record was accurately coded and accurately reflected the services provided	QA Staff
Week 1-3	Review records to determine if records contain sufficient documentation to support the charged bill.	QA Staff
Week 1-3	Review records to determine if services provided were "medically" necessary.	QA Staff
Week 1-3	Review records to determine if any incentives for unnecessary services or items exist	QA Staff
Week 1-3	Review records to determine if youth/family records contain sufficient documentation to support the charged bill.	QA Staff
Week 1-3	Review records for the causes of back billing and how to reduce the occurrence	QA Staff
Week 1-3	Review records for youth being transitioned at the beginning of the subsequent month to ending services to ensure that previous month's services can be legitimately billed to Medicaid.	QA Staff
Week 1-3	Review records for the causes of nonpayment in cases where the Medicaid billing window has expired.	Medicaid Biller and QA Staff
Week 1-3	Review records to determine if progress notes during the quarter were submitted in the required 72 hours of meeting with the youth.	QA Staff
Week 1-3	Review records to determine if supervisors accurately reviewed the billing criteria during the determination of whether services were billable for the month.	QA Staff

Week 4	Collect and aggregate data regarding these queries: 1. the percentage of errors in records for each query reviewed in each of the 4 categories of records. 2. An overall aggregate of the percentage for each query for the total number of records reviewed.	QA Staff
Week 4- 5	Write interim/final report	Corporate Compliance Officer

I. Documentation Requirements: The Corporate Compliance Officer will review aggregated data and create a quarterly report for each audit completed during the fiscal year. The 4th quarter audit will also act as a final report that provides a summary of data from all audits performed during the year. All reports created and the data used to create them will be labeled as "Confidential" and will be maintained by the Corporate Compliance Officer on the restricted Compliance Microsoft TEAMS site. Any documents sent to, received from, or prepared by legal counsel will be marked "Confidential/Attorney-Client Privileged."

Contents of reports will include information about the type, method, size, scope and goals of the audit, the aggregated data gathered from the records, identification of problems and suggested resolutions for those problems and, if warranted, suggestions for modifications of the goals for future audits in order to more fully investigate issues identified.

J. Distribution of Audit Findings: The quarterly and annual Coding and Billing Audit reports will be shared with the:

- Chief Executive Officer
- Chief Financial Officer
- Director of Operations
- Director of Quality and Compliance
- Quality Assurance Manager
- At the discretion of the CEO, summaries of the audit findings will be shared with the additional leadership and supervisory level staff.