

LEWIS COUNTY CORPORATE COMPLIANCE PROGRAM

It is the policy of Lewis County (the “County”) to assure that its employees, agents and representatives comply with all applicable state and federal laws, rules and regulations. In particular, it is the County’s policy to establish a Corporate Compliance Plan to assure that each of its departments who directly provide medical services and receive federal and state payments for such services, including those from the Medicaid program, are in compliance with all relevant laws and regulations and the requirements related to implementation of a compliance program, including those set forth in Social Services Law § 363-d and 18 NYCRR Part 521. Therefore, the within Corporate Compliance Program is hereby declared to be the policy of Lewis County with regard to such compliance issues and shall be incorporated into the Administrative Manual for Lewis County.

INTRODUCTION

Lewis County provides medical and health related services for which it receives payments from Medicare, Medicaid and third part insurers. Such services are provided through several departments, including the Mental Hygiene Department, the Public Health Department, and the Lewis County General Hospital and Residential Health Care Facility (collectively, “Covered Departments”). The County finds that it is in the public interest to establish a “corporate” (meaning throughout County government) compliance program to ensure that quality medical and health related services are provided in a manner that fully conforms to all applicable state and federal laws and regulations. To meet this goal, Lewis County hereby establishes the within Corporate Compliance Plan to assist its departmental staff in adhering to state and federal law, as well as health care program requirements, while conducting services in the highest ethical manner. Each of the Covered Departments shall create a compliance plan that conforms to the policies outlined herein and contain specific policies and procedures, including identification of risk areas that apply to the services provided by the Covered Department.

Lewis County is committed to prevention, detection and resolution of instances of conduct that do not conform to federal, state and county laws, rules and regulations, as well as Lewis County's ethical and organizational policies. The goals of the Compliance Program are to:

- Improve quality, efficiency and consistency of services,
- Demonstrate a strong commitment to corporate and individual integrity and ethical behavior,
- Identify weaknesses in internal systems,
- Create a centralized source for distributing information on compliance,
- Identify illegal and/or unethical conduct and/or conduct that does not conform to federal or state laws, rules and regulations and/or the rules and regulations of the County and the relevant department,
- Develop a system for employees and others to report potential unlawful or improper conduct, without risk of retaliation or intimidation,
- Formulate procedures for investigating alleged misconduct, and

- Initiate corrective action and prevent further fraud, abuse or other inappropriate activities.

I. COMPLIANCE PROGRAM

A. Definitions:

The following definitions shall apply to this Corporate Compliance Program:

- a. "Covered Department" shall mean a County department or administrative unit that directly provides medical assistance to members of the public, as defined by Social Services Law § 363-d, including the Mental Hygiene Department, Public Health Agency and Lewis County General Hospital and Residential Health Care Facility.
- b. "Covered Person" shall be deemed to include each employee within a Covered Department; any volunteer providing services to such Covered Department; each member of any board or committee that governs, supervises, oversees or advises such Covered Department (whether such member serves by reason of appointment, election or as a volunteer); any County employee who is responsible for managing, supervising, or overseeing a Covered Person whether or not employed within a Covered Department; and any contractor or vendor who provides services to or for the benefit of a Covered Department.

B. Fundamental Components of the Lewis County Compliance Program

The County of Lewis has identified twelve (12) key components to its Compliance Program.

- (1) Establish written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;
- (2) Designate one or more employees as Compliance Officers who are vested with responsibility for the day-to-day operation of the compliance program; such employees' duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the Covered Department's chief executive or other senior administrator regarding compliance issues within that department and shall periodically report to the County's Compliance Committee as well as directly to the Board of Legislators or their designees on the activities of the compliance program;
- (3) Develop and implement training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee,

appointee or associate, executive and governing body member;

- (4) Develop communication lines to the responsible compliance officer, as described in paragraph (2) above, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;
- (5) Establish policies that will (i) encourage good faith participation in the Compliance Program by all affected individuals and (ii) enforce the standards of conduct expected by this Compliance Program. Such policies will be fairly and firmly enforced throughout all Covered Departments and consistent with the personnel policies and applicable collective bargaining agreements that affect each such Department.
- (6) Develop a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including internal audits and as appropriate external audits, and for evaluation of potential or actual noncompliance as a result of such self-evaluations and audits;
- (7) Establish a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;
- (8) Establish a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, participating in self-evaluations, audits and remedial actions, and reporting to the appropriate official instances of perceived non-compliance.
- (9) Establish a policy whereby the County will not employ, contract with, or do business with any individual or organization who has been convicted of a criminal offense related to health care or who are listed by a State or Federal agency as debarred, excluded or otherwise ineligible for participation in any state or federally funded health care program. In furtherance of this policy, each Covered Department shall establish procedures to regularly conduct exclusion (sanction) screening of all current and proposed employees, Board members, and contractors. Additionally, each Covered Department shall establish policies and procedures to assure that every employee whose job duties requires a professional license or credential take the necessary steps to maintain their license or credential in good standing at all times.
- (10) Establish clear guidelines for the creation and retention of all documents and records pertaining to the provision of medical services and to assure that such documents are created and maintained in timely and accurate manner.
- (11) Establish policies and procedures that will assure that all billings for patient services are appropriate for all third party payers and consistent with all state and federal laws, rules

and regulations.

- (12) Establish policies and procedures for responding to all government inquiries, whether state or federal, in order to assure not only full and complete cooperation with such inquiries, but also that all County employees who receive such inquiries have full access to appropriate County resources including, where necessary, legal counsel.

This document describes these twelve (12) basic elements as they fit within Lewis County and details the fundamental principles, values, and operational framework for compliance within Lewis County. These Policies are outlined below:

C. Compliance Program:

1. Written Policies and Procedures

- a. **The Corporate Policy.** In addition to any other applicable standard of conduct for its employees, Lewis County hereby establishes this Corporate Compliance Program together with the attached Health Services Code of Conduct (“HSCOC”). To the extent that any portion of the HSCOC conflicts with the Standards of Conduct contained in the Lewis County Personnel Handbook, the Lewis County General Hospital Personnel Handbook or any other personnel policy, handbook or manual, the terms of the HSCOC shall control. The HSCOC shall apply to all Covered Persons to reinforce their dedication to quality services as well as compliance with federal and state law. A Covered Department may add to the HSCOC such elements that may apply specifically to that department; however, in no event shall a Covered Department have a code of conduct that is in any way less restrictive than the HSCOC. All Covered Persons shall be provided a copy of this Corporate Compliance Program including the HSCOC. Every Covered Person must sign an acknowledgement reflecting their receipt and agreement to abide by this Program and the HSCOC. The acknowledgment will be retained in the Covered Person’s compliance training file. To the extent that a Covered Department is able to provide this document to its employees electronically and to record their acknowledged receipts electronically, this is to be encouraged, provided that the electronic records are maintained in a secure location and in accordance with the records retention policy set forth in Section 10.
- b. **Annual review of Corporate Policy.** This Corporate Compliance Program and the HSCOC shall be reviewed at least annually by the Corporate Compliance Committee (established herein below) and any applicable legislative committee designated to oversee compliance activities. Revisions, if any, will be adopted by the Lewis County Board of Legislators, inserted in the County’s Administrative Manual, and copies will be distributed to all Covered Persons. The County Manager or his or her designee shall certify to the New York State Office of Medicaid Inspector General (“OMIG”), upon form(s) provided by OMIG on its website, that a county compliance program meeting the regulatory requirements is in place.
- c. **Departmental Compliance Plans.** Each of the Covered Departments shall establish

or have already established written Compliance Plans, consistent with the policies set forth herein, that will contain the specific guidance to Covered Persons within that Department on ways of reducing fraud and abuse. The departmental compliance plans and procedures are intended to support the current operational practices within these Departments and, when possible, are integrated within existing policies and procedures. The Compliance Officer for each Covered Department shall review the departmental compliance plan at least annually. Revisions, if any, shall be recommended to the respective governing administrator or board for such Covered Department and adopted, as necessary. Copies of any revisions shall be distributed to all affected Covered Persons and written or electronic acknowledgements of receipt shall be maintained by the Compliance Officer.

(1) **Mandated Subject Areas.** The Compliance Plans for each of the Covered Departments shall address the following subject matters (18 NYCRR 521.3):

- (a) Billings;
- (b) Payments;
- (c) Medical necessity and quality of care;
- (d) Governance;
- (e) Mandatory reporting;
- (f) Credentialing; and
- (g) Other risk areas that are identified by the Covered Department and/or the Corporate Compliance Committee.

d. **Continuing Review of Departmental Policies.** The Compliance Officer within each Covered Department shall bring to the attention of the administrator(s) within such Department any newly identified risk that is revealed as a result of any internal or external risk analysis and shall recommend appropriate actions that may include, without limitation, the dissemination of new policies and procedures or revisions of old ones as well as action plans, where necessary, to address those risks.

e. **Communication to Employees.** Compliance policies and procedures will be clearly communicated to all Covered Persons in writing or electronically. Methods for accomplishing this may include administrative notification, posting of policies and procedures, inclusion in documents such as staff handbooks, position descriptions, performance evaluations, newsletters, as well as through training.

2. Compliance Officer and Compliance Committee

The Lewis County Corporate Compliance Committee (CCC) is hereby established. The purpose of the CCC is to monitor the operation and implementation of the Corporate Compliance Program within the County and within each Covered Department. The CCC is chaired by the County Attorney and will consist of the Public Health Director, the Director of Community Services, the

Chief Executive Officer of the Lewis County General Hospital, the County Manager, the County Attorney, and each of the respective CO's. This Committee will meet as often as deemed necessary, provided that it meets at a minimum on a quarterly basis. The CCC will document those in attendance, issues discussed and decisions made, if any. These minutes will be retained by the Clerk of the Board of Legislators.

The chief administrator, Director or Department Head of each Covered Department shall appoint one or more Compliance Officers ("CO") within such Department. The primary responsibility for the Compliance Officer(s) is to implement, manage, and monitor this Corporate Compliance Program within such department together with any departmental compliance policies and procedures. The CO's job duties at a minimum involve:

- Overseeing and monitoring the implementation of the Corporate Compliance Program as well as departmental compliance policies and procedures within the Covered Department,
- Reporting to the applicable Director or Department Head of a Covered Department changes in the law and applicable regulations as well as policies and procedures of federal, state and local government and private-payer health plans with regard to compliance issues and recommend changes to the departmental compliance plan and, if applicable the Corporate Compliance Program,
- Developing, coordinating, and participating in an educational and training program that focuses on the elements of the Compliance Program, and seeks to ensure that all Covered Persons are knowledgeable of, and comply with, pertinent federal, state and local standards,
- Assisting in coordinating internal compliance reviews and monitoring activities, including periodic reviews and audits of the Covered Departments,
- Independently investigating matters related to compliance, including coordinating internal investigations and monitoring corrective actions,
- Developing policies and programs that encourage Covered Persons to report suspected fraud and other improprieties without fear of retaliation.

To assist each CO in promoting the effectiveness of the Compliance Program, each Covered Department shall establish a compliance committee comprised of the administrative personnel within the department that are responsible for auditing and billing claims, individuals knowledgeable regarding the provision and documentation of services, individuals involved in the quality assurance and incident review process and an individual familiar with the credentialing of Covered Persons. Departmental compliance committees shall meet at least monthly to monitor compliance activities within the Covered Department, advise the CO and address any areas of risk identified by the CO. Each Covered Department is responsible for documenting these meetings, those in attendance, issues discussed and decisions made, if any. Minutes shall be maintained by the Director or Department Head, and copies thereof shall be distributed to the CCC.

3. Training and Education

The CO within each Covered Department is responsible for ensuring that policies regarding

compliance are disseminated and understood by that Department's Covered Persons. To accomplish this objective, the CO will assist with the development and implementation of a systematic and ongoing training program of compliance policies.

The CCC will monitor all compliance training throughout the County and shall take such steps as are necessary to assure that all Covered Persons have participated in compliance training, at least once annually. Such training shall include how to identify and report compliance issues, and the consequences both to Lewis County and to Covered Persons for failing to comply with applicable laws and regulations. The CCC will also oversee the training and education being provided by each CO to assure that each Covered Department provides their Covered Persons with adequate information and training on the compliance policies and procedures that pertain to that department. The purpose of this training is to emphasize the importance of the Corporate Compliance Program and Lewis County's commitment to honesty and integrity throughout its health care system.

A variety of methods will be used to accomplish this training including annual review sessions, new employee orientation, re-training, supervisory conferences, email communications, visual aids, and interactive training programs. Training instructors may come from both inside and outside the County government.

Each Covered Department shall be responsible for establishing a system to document that such training has occurred for the Covered Persons within that Department. It shall be the responsibility of each CO to assure that records are retained for each Covered Person within their respective departments to include at a minimum: receipts of Compliance policies and procedures, notices, attendance sign-in sheets and training agendas. Individual training documentation should also include the dates, types of training, test scores and hours spent per Covered Person. The CCC shall maintain training files for each Covered Person not employed within a Covered Department (i.e., governing board members), such files to be kept by the Clerk of the Board of Legislators.

Adherence to policies will be addressed at staff orientations and at ongoing training sessions. Covered Persons will be expected to demonstrate a sufficient level of understanding as a result of compliance training and must pass a review test at the end of the annual training with a minimum score of 80%. Those scoring less must repeat the training.

If a particular compliance issue or risk issue develops, the CO and CCC may recommend that identified persons attend additional training to address the risk issue. The CO may also establish the need for additional training within the Covered Department, whenever issues are discovered. The CCC may also direct that training be provided to all Covered Departments when necessary to address specific risks.

Adherence to the provisions of the Corporate Compliance Program as well as the departmental compliance plan, including attendance and completion of compliance training, will be a factor in each Covered Person's annual performance evaluation. Failure to comply with training requirements or to attend scheduled training sessions may result in disciplinary action.

The CCC will conduct periodic evaluations of training and education programs to determine, and if necessary improve, the value, effectiveness, and appropriateness of any such program.

4. Communication

Lewis County strives to ensure that open, two-way communication lines to each CO are accessible to all Covered Persons to allow compliance issues to be reported. This open communication is essential to maintaining an effective compliance program. It increases the County's ability to identify and respond to compliance problems and reduces the potential for fraud, abuse and waste. Without help from Covered Persons, it would be difficult to learn of possible compliance issues and make necessary corrections.

Each CO will use various communication methods to encourage the reporting of compliance concerns. As a general practice, Covered Persons will be directed to address questions about operational issues to the supervisor responsible for that area. Training materials will inform Covered Persons that they may report to the CO any activity they believe to be inconsistent with policies or legal requirements. Covered Persons may contact the CO by phone, email, in person or in writing. The CO will strive to maintain confidentiality of the reporter's identity; however the CO cannot guarantee this confidentiality. An additional reporting method available to all Covered Persons is the installation of a locked suggestion box in each of the Covered Departments, thus allowing for anonymous and confidential reporting. Additionally, each Covered Department shall establish and post a "hotline" telephone number that will provide direct telephone access to the CO within that department. The hotline telephone number will be given to each Covered Person and posted on the employee bulletin board within the department.

Covered Persons who report possible compliance issues in good faith will not be subjected to retaliation or harassment as a result of the report. Concerns about possible retaliation or harassment should be reported to the applicable CO, the Director of the applicable Covered Department or the County Manager.

Each Compliance Officer shall maintain a log of the reported compliance concerns. This log will record the assigned number of the complaint; the date received; the source the information obtained; the general issue; the corrective action necessary and whether the outcome was pended or resolved. Any complaint resulting in investigation shall remain in a separate file. The log will be treated as a confidential document whereby access will be limited to those persons at Lewis County with specific responsibility for compliance matters. The CO will discuss the log on a regular basis with the departmental compliance committee, the CCC and the County Manager.

5. Enforce Standards

Any Covered Person who violates any of the policies set forth herein, including without limitation, the Health Services Code of Conduct, or violates the requirements of the applicable departmental compliance plan, will be subject to disciplinary action. The appropriate discipline will depend on the nature, severity and frequency of the violation and may result in any or all of the following actions:

- Oral warnings
- Written warnings

- Probation
- Suspension
- Termination from employment (or, if applicable, removal from a governing board or committee, termination of contract, etc.)
- Financial restitution

For those Covered Persons who are licensed or credentialed by New York State or any other licensing or credentialing agency as a prerequisite to performing a professional service, and who for whatever reason, fail or neglect to maintain their license or credential may be subject to immediate suspension from their employment with the County until such license or credential may be restored. (*See*, Section 9, “Non-Employment or Non-Retention of Sanctioned Individuals/Credentialing”)

Intentional or reckless noncompliance will elicit the most severe sanctions. The consequences of noncompliance will be consistently and equitably enforced. Covered Persons will be held to the highest standards with sanctions for the following noncompliance:

- Failing to report suspected problems,
- Participating in non-compliant behavior,
- Encouraging, directing, facilitating, or permitting non-compliant behavior,
- Failing to perform any obligation or duty required of Covered Persons relating to compliance with applicable laws or regulations,
- Failure of supervisory or management staff to detect non-compliance with applicable policies where reasonable diligence would have led to the discovery of any violations or report such non-compliance to the CO.

Covered Persons who violate federal or state laws, rules or regulations pertaining to Medicaid compliance may also be subject to criminal prosecution including fines, prison terms and civil damages.

All disciplinary actions of County Employees will follow the "Progressive Discipline" guidelines outlined by the applicable personnel handbook. Disciplinary actions against members of a governing board or committee shall be taken in accordance with applicable laws, rules and County policies. Disciplinary action against a contractor shall follow applicable termination provisions in the respective contract.

6. Internal Auditing and Monitoring

An important element of an effective compliance program is identifying and correcting any deficiencies. Identification efforts include built-in monitoring systems, and periodic small reviews conducted by each CO, appropriate Directors, Department Heads and designated personnel, as well as larger, more formal reviews and/or audits conducted by both internal and external auditors.

Each CO is responsible for ensuring that internal compliance auditing takes place on a regular basis. External audits may be requested by any CO and will be conducted upon the approval of the CCC. Compliance audits are conducted as a proactive way of monitoring compliance in areas

of potential risk. The Directors and/or Department Heads of the Covered Departments will keep the applicable CO informed of all audits and/or reviews scheduled and the results of such audits or reviews.

Auditors and reviewers, including each CO, will have access to all necessary documents including those related to claim development and submission, patient records, e-mail and the contents of computers and electronic storage devices. Auditors and reviewers will at all times bear in mind confidentiality requirements.

The CO within each Covered Department will be notified of the results of all audits performed by that department's personnel, consultants, or government auditors. Further action, if any, by the CO will be discussed with the CCC.

7. Response to Offenses and Corrective Action Plans

Lewis County strives to ensure that all issues reported of suspected noncompliance are promptly and thoroughly investigated under the guidance of the CO and CCC. The goals of an internal investigation include:

- Discovering facts and circumstances related to allegations of noncompliance,
- Assessing the significance of the facts discovered to determine whether the conduct was in violation of the this Corporate Compliance Program, the HSCOC, or any departmental policy or procedure,
- Recommending both disciplinary actions and corrective actions.

In the event that a CO, Department Head or Director discovers credible evidence of misconduct and, after a reasonable inquiry, believes that the misconduct constituted a violation of criminal, civil or administrative law or regulation, then they will immediately consult with the County Attorney. An investigation of the allegations will be promptly initiated. The applicable CO and Department Head or Director will work closely together the County Attorney in determining each person's role in the investigation and the steps necessary to complete the investigation. In the initial fact finding stages of an investigation, a team approach may be advantageous. The County Attorney will notify the CCC immediately of any suspected violations.

The County Attorney will maintain primary responsibility for conducting the investigation, with the assistance of outside counsel, if deemed necessary. Department Heads or Directors are expected to fully assist the County Attorney with the investigation. Upon the recommendation of the County Attorney, the investigation may be turned over to applicable outside authorities and/or outside investigators who may assist in the inquiry.

The County Attorney or his or her designee, may conduct interviews with any employee and with other persons; may review any document including but not limited to those related to the claim development and submission process, patient records, emails, and the contents of computers and electronic storage devices; and may undertake other processes and methods as the County Attorney or the CCC deems necessary.

If the investigation ultimately reveals that criminal or civil violations have occurred, the County Attorney will notify the appropriate federal and state officials, in consultation with outside counsel, if deemed necessary. Appropriate federal and state authorities include the Centers for Medicare and Medicaid Services, NYS Office of Medicaid Inspector General, NYS Commission on Public Integrity, Office of the State Comptroller, Criminal and Civil Divisions of the Department of Justice, the U.S. Attorney, and the investigative arms for the agencies administering the affected federal or state health care programs, such as the state Medicaid Fraud Control Unit, the Defense Criminal Investigative Service, and the Offices of Inspector General of the Department of Health and Human Services and the Department of Veterans Affairs.

Lewis County will respond promptly and appropriately to the discovery of possible criminal activity as well as the discovery of other non-compliant activity. In the event an investigation reveals what appears to be criminal activity on the part of any Covered Person, the following actions shall be taken in consultation with the County Attorney:

- All billing involved in the situation will be discontinued until such time as appropriate corrections can be made,
- A summary of the results of the investigation shall be sent for appropriate disciplinary action to the CCC. Pending disciplinary action, any such Covered Person may be removed from any position with oversight of or impact upon the claims development and submission process,
- Federal, State, and/or local agencies shall be notified in an appropriate period of time and no later than sixty (60) days as deemed appropriate.

If the results of an investigation indicate that corrective action is required, the County Attorney, and the applicable CO will work closely with the appropriate Department Head or Director to decide the necessary steps to take. Action plans will be designed to ensure not only to correct the specific issue, but also to prevent the issue from re-occurring. The corrective action plan may require additional staff training, reassignment of duties or functions, personnel action, terminating contractual relationships, repayment, revision or creation of policies and procedures, restitution or disclosure to outside agencies. The corrective action plan will be written by the appropriate person as determined by the CCC.

Each CO will maintain a separate file of all investigations that have been initiated within their respective departments. At a minimum, for those investigations where the allegations were unsubstantiated, the file should contain a report of all steps taken during the investigation and the final outcome. If the investigation identifies issues of noncompliance, the CO will prepare a report which describes the nature of the situation, summarizes the investigation process, and if possible, estimates the nature and extent of the resulting overpayment. In addition, all corrective actions plans will be filed with each compliance investigation. The CO will follow up on each corrective action plan to ensure implementation. This report will be reviewed by the CCC and presented to the CCC.

Attached to the Corporate Compliance Plan is a summary of the Federal and New York statutes relating to fraud including those involving the False Claims Act and the Whistleblower Protection Act.

8. Non-retaliation policy

It is the policy of Lewis County that no County employee, supervisor or elected official shall engage in or threaten to engage in a “retaliatory personnel action” against any other County employee or other Covered Person for good faith participation in this Corporate Compliance Program. Good faith participation in the program may include but is not limited to:

- disclosing, or threatening to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud;
- providing information to, or testifying before, any public body or officer conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or
- objecting to, or refusing to participate in any such activity, policy or practice in violation of a law, rule or regulation.

For purposes of this policy, “retaliatory personnel action” means the discharge, suspension or demotion of an employee or other Covered Person, or other adverse action taken against an individual in the terms and conditions of his or her association with the County.

To further assure that all Covered Persons are fully aware of their rights and protections available under the law, attached to this Policy are copies of the pertinent portions of state and federal laws commonly referred to as “whistleblower” protections.

9. Non-Employment or Non-Retention of Sanctioned Individuals/Credentialing

Individuals who have been convicted of a criminal offense related to health care or who are listed by a Federal agency as debarred, excluded or otherwise ineligible for participation in any federally funded health care program will not be employed or have another relationship with the County. In addition, individuals who are excluded from participation in the New York State Medicaid program will not be employed or have another relationship with the County.

Current employees or others currently associated with the County who are charged with criminal offenses related to health care or proposed for exclusion or debarment from a federally or state funded health care program should be removed from direct responsibility for or involvement in any federally or state funded health care program until resolution of such criminal charges or proposed debarment or exclusion. If the resolution results in conviction, debarment or exclusion of the individual, the County will terminate its employment of or other association with that individual.

It is the County’s policy to inquire into the background of applicants with respect to matters relating to any current or prior disciplinary action, investigation, audit or review relating to the provision of health care goods or services, or any claim for reimbursement.

The following will be queried with respect to potential employees, independent contractors, agents and Board Members, and shall be reviewed at least quarterly for all existing employees, independent contractors and Board Members:

- a) General services administration: list of parties excluded from Federal programs. The URL address is <https://www.epls.gov/epls/search.do>.
- b) HHS/OIG cumulative sanction report. The URL address is <http://exclusions.oig.hhs.gov/>.
- c) NYS Medicaid Fraud Database. The URL address is http://www.omig.state.ny.us/data/component/option.com_physiciandirectory/.
- c) Licensure and disciplinary record with NYS Office of Professional Medical Conduct (Physicians, Physician Assistants) (the URL address is <http://w3.health.state.ny.us/opmc/factions.nsf/physiciansearch?openform>) and/or New York State Department of Education (other licensed professionals) (the URL address is <http://www.op.nysed.gov/rasearch.htm#name>).

It is also the County's policy to assure that all professional services rendered by or on behalf of Lewis County shall be performed only by persons who have the necessary and appropriate licensing and credentials for such services. Accordingly, all Covered Department employees are expected to attain and maintain all necessary requirements for licensing in their respective disciplines to enable them to perform services. Appropriate and thorough licensing checks and credentialing will take place upon initial hire and on an ongoing basis. References will be checked and verification of educational qualifications will be performed prior to employment or other association with the Covered Departments. Failure to attain and maintain necessary licenses and credentials shall be grounds for immediately suspending such individual from performing such services until the applicable license or credential is obtained as well as further disciplinary action up to and including termination.

Each Covered Department shall retain records of all exclusion checks and credential inquiries performed as well as the results.

10. Record Creation and Retention

One of the primary purposes of maintaining and retaining records is to demonstrate that the County provides medically appropriate services to its clients, patients and residents. Further, appropriate and complete documentation provides the basis on which reimbursement is sought from third party payers. Maintaining appropriate documentation is vital to the continued success of the County. Thus, all Covered Persons have an obligation to maintain accurate and complete records.

It is the policy of the County to comply with at least the minimum standard required by Federal and State laws and regulations. In New York State, Medicaid records must be retained for a least six years from the date of service. Due to federal laws involving false claims, records should be retained for a period of ten years. Records of minors may be required to be maintained longer.

Covered Persons are also expected to maintain complete, accurate and contemporaneous records as required by the County and payers. The term “records” includes all documents, both written and electronic, that relate to the provision of services or that provide support for billing services to all payers. Records must reflect the actual service provided.

All records required either by Federal or State law or by this Compliance Plan will be appropriately created and maintained. Records should never be altered without permission where required. In the case of a necessary alteration, the alteration should be signed and dated by the staff member altering the document. Specifically, the following process should be followed:

- a. cross out the incorrect entry with a single line ensuring that it may continue to be reviewed;
- b. enter the correction;
- c. sign the correction;
- d. where applicable, enter the time and date the correction was made; and
- e. provide an explanation of the reason for the change if not readily apparent.

Signatures should always be accompanied by the date that the signature was made. Dates in all cases should include the month, date and year. Documents must never be backdated or predated. Signature stamps shall not be used. Under no circumstances shall any person sign the name of another individual.

Because the County provides services under State and Federal health care programs, State or Federal government agencies may from time to time seek access to the County’s records. If a Covered Person is requested to supply any records or documentation to individuals or entities outside of the County, the Covered Person should immediately contact his or her supervisor and the CO.

The County is dedicated to protecting the privacy and confidentiality of all records relating to the County’s clients/patients/residents and personnel. Covered Persons should assume that all information relating to the provision of services and to billing is considered confidential. For example, information that the County considers confidential includes any and all records pertaining to clients/patients/residents, financial information, all personnel information, client lists, and any other information that is not generally disseminated to the public. This list is not exhaustive, and, therefore, if any question arises regarding the potential confidentiality of any information, individuals are instructed to seek guidance from the CO. In particular, Covered Persons are directed to refrain from discussing any client/patient/resident names or details pertaining to services provided to any clients/patients/residents with any person outside of the County, unless expressly authorized by the CO.

11. Billing

The County is committed to prompt, complete and accurate billing of all services provided to clients/patients/residents. Billing shall be made for services provided, adhering to all terms and conditions specified by the government or private payer and consistent with industry practice. No false or misleading entries shall be made or submitted on any bills or claim forms, and no individual associated with the County shall engage in any arrangement, or participate in such an

arrangement at the direction of another individual associated with the County that results in such prohibited acts. Any false statement on any bill shall subject the individual to disciplinary action by the County, including possible termination of the individual's relationship with the County, subject to any relevant collective bargaining agreement. The County is committed to billings which are accurate, reliable, timely and valid.

False claims and billing fraud may take a variety of forms, including, but not limited to, false statements supporting claims for payments, misrepresentations of material facts, concealment of material facts, or theft of benefits or payments from the party who is entitled to receive it. If there is any question as to appropriate billing, the CO should be consulted.

12. **Response to Government Inquiries¹.**

State and federal law enforcement and regulatory agencies routinely conduct interviews or request documents or records to gather information during audits, inquiries, and investigations. It is the County's policy to cooperate with and properly respond to all government inquiries and investigations.

The County also recognizes that it has established a policy to defend its officers and employees in the performance of their official duties (provided, however, that the County is not responsible for defending a County officer or employee who is alleged to have committed a crime). It is in the balancing of these two policies, that the County establishes the following protocols for all Covered Persons to follow, whenever they receive a request either in person or in writing from a government agency:

A. Visits to a County facility.

1. Remain courteous and professional at all times when dealing with governmental investigators or agents.
2. Announcement of an impending visit by any government investigator or auditor should be immediately reported to the chief administrator, Director or Department Head of your department, who will be responsible to notify the departmental Compliance Officer and County Attorney.
3. If an individual arrives at any County facility and identifies himself or herself as a government auditor, investigator or other representative, request identification and the reason for the visit (**do not attempt to photocopy credentials, as this is a violation of federal law**). Record the name, address and contact information of the individual and the agency he or she represents.
4. Ask the individual to wait in an unused office or a location where business is not conducted.

¹ This policy does not apply to visits by regulatory agencies to perform program certification or quality assurance functions.

5. Immediately contact the chief administrator, Director or Department Head of the department, who will contact the departmental Compliance Officer and the County Attorney.
6. The chief administrator, Director or Department Head in consultation with the County Attorney, and, as necessary, outside legal counsel, will coordinate the response to inquiries and investigations by regulatory and prosecutorial agencies. The chief administrator, Director or Department Head will designate the employee(s) to be responsible for responding to the investigator/agent's questions.
7. Await direction from the County Attorney. PLEASE NOTE: Employees are free to speak to government investigators or auditors; however, you are not required to submit to questioning. It is strongly recommended that employees wait for instruction from the County Attorney or outside legal counsel before submitting to questioning or an interview. The same applies to providing documents or records.
8. **No individual associated with the County shall alter, revise, delete or destroy any material, including without limitation, any document or writing, whether created, stored or distributed on paper, computer, word processor, disk or tape, in digital or electronic form, regardless of format, once such inquiry has been commenced. It is the County's policy that any document required to be retained pursuant to this Policy must be preserved in its original form. Copies of all documents provided in response to a government inquiry shall be maintained.**

B. Written Requests.

1. Upon receipt of a written (including electronic) request for information or documentation, immediately contact the chief administrator, Director or Department Head of the department, who will review the request with the departmental Compliance Officer and the County Attorney.
2. The chief administrator, Director or Department Head in consultation with the County Attorney, and, as necessary, outside legal counsel, will coordinate the response to inquiries and investigations by regulatory and prosecutorial agencies. The chief administrator, Director or Department Head will designate the employee(s) to be responsible for responding to the investigator/agent's written requests.
3. Maintain copies of all correspondence and documents provided in response to such written request.

C. Subpoenas.

A subpoena is an official demand for testimony or the disclosure of documents or other information. They may originate from law enforcement or administrative agencies. Every subpoena requires a careful legal review prior to response.

1. If the government inquiry comes in the form of a subpoena (either by mail or in person), the request should be immediately forwarded to the chief administrator, Director or

Department Head as the case may be, who shall immediately notify the departmental Compliance Officer and the County Attorney. These individuals, along with outside legal counsel, if deemed necessary, will coordinate the response.

2. If the subpoena is delivered in person, the staff on duty should obtain the name, title, and telephone number of the serving agent/investigator.
3. Provide the agent/investigator with direction or information so they may deliver the subpoena to the appropriate or requested individual.
4. Await further instruction from the County Attorney. PLEASE NOTE: Employees are free to speak to government investigators or auditors; however, you are not required to submit to questioning. It is strongly recommended that employees wait for instruction from the County Attorney or outside legal counsel before submitting to questioning or an interview. The same applies to providing documents or records.

D. Search Warrants.

A search warrant permits agents to immediately seize documents and other types of information. The execution of a search warrant can be seriously disruptive and frightening for many employees. Furthermore, if not handled properly, an organization subject to a search warrant may compound its problems.

1. Employees will remain courteous and professional when dealing with agents executing a search warrant.
2. Employees will not interfere with the lawful execution of a search warrant.
3. Obtain and record the name of the lead agent and the agency they represent. **Do not attempt to photo copy the credentials of an agent – it is a violation of federal law.**
4. Request to view and photocopy the search warrant document.
5. Immediately contact the chief administrator, Director or Department Head and provide him/her with details of the search warrant. The chief administrator, Director or Department Head will contact the Corporate Compliance Officer and the County Attorney and provide details of the search warrant. The chief administrator, Director or Department Head will identify the employee to be responsible for responding to the agent's questions.
6. Request an "inventory list" of the documents and items seized by the agents. Ensure that it is detailed enough to properly identify the documents and items taken by the agents. Maintain a separate record of the areas searched, listing the documents/items seized from the area.

7. Other than providing information to direct the agents to information requested, do not submit to any form of questioning or interviewing.
8. Always remain present while the agents are conducting the search.

9. Senior Management Responsibilities:

The chief administrator, Director or Department Head will carefully examine the search warrant (with legal counsel, if possible) to:

- Determine the specific areas or locations it covers;
- Ensure that it is being executed during the hours indicated on the document (most warrants should limit the hours they can be executed, e.g. “daylight hours”);
- Ensure that it has not expired (all warrants should have an expiration date); and
- Ensure that it is signed by a Judge (all warrants should be signed by a Judge).

Politely object if there is any overt flaw in the search warrant (as described above) or if the agents are searching anything deemed to be outside the scope of the warrant. Do not interfere should agents proceed and search. Note the fact for legal counsel to support a future protest.

E. Visits to any location outside a County facility (e.g., personal residence):

PLEASE NOTE: Employees are free to speak to government investigators or auditors; however, you are not required to submit to questioning. The following is provided as general information regarding off-site visits:

1. Individuals have the right to decline an interview or to postpone an interview until they have had an opportunity to seek legal counsel or other advice.
2. Employees who agree to be interviewed should always be truthful. If they do not know the answer to a question, they should say so.
3. Employees should report any off-site visits by government agents, investigators, or auditors to the chief administrator, Director or Department Head of their department. The chief administrator, Director or Department Head, as the case may be, will notify the Compliance Officer and the County Attorney.
4. Refer to policy on Search Warrants, if applicable.

CONCLUSION

Lewis County's Corporate Compliance Plan provides an administrative framework for addressing

the areas most likely to present a compliance risk. It establishes specific policies and procedures intended to educate Covered Persons of their obligations with respect to these risk areas. These compliance policies are consistent with and guided by our Health Services Code of Conduct. It is Lewis County's goal to communicate to all Covered Persons as clearly as possible Lewis County's expectations of ethical and professional conduct. The Health Services Code of Conduct is not a complete guide to all of Lewis County's policies or to all Covered Person responsibilities under the law. It provides general guidelines to help Covered Persons resolve ethical and legal issues and demonstrates Lewis County's commitment to respect, honesty and integrity. The principles outlined should be a guide for Covered Person's decisions and actions.

Lewis County requires all Covered Persons to sign an acknowledgment confirming they have received the Compliance Plan and the Code of Conduct, understand it represents mandatory policies of Lewis County and agree to abide by it. New employees are required to sign this acknowledgment as a condition of employment. Adherence to and support of Lewis County Compliance Plan and participation in related activities and training is considered in decisions regarding hiring, retention, engagement, promotion, and compensation for all Covered Persons.

Lewis County Health Services Code of Conduct

Lewis County is committed to providing services with compassion and integrity. For that reason, Lewis County has developed this Code of Conduct which establishes the legal and ethical standards that govern our expectations for all Covered Persons as it particularly relates to health services, including mental hygiene, public health and medical services.

Please take the time to carefully read through this Code of Conduct. If you have any questions about any of the information contained in the Code of Conduct, please ask. We believe that our commitment to these standards will enable all staff to effectively work together to provide the highest standard of care to our community.

Lewis County's goal is to communicate to all staff its expectations of ethical and professional conduct and to ensure that every staff member understands these expectations. By signing the Health Services Code of Conduct, each Covered Person agrees to the following:

Quality of Care:

- Treat every client with consideration, courtesy, dignity and respect.
- Provide the highest quality of service by meeting the needs of our clients/patients/residents with the utmost care and courtesy.
- Perform our duties in a responsible, reliable, appropriate and cost effective manner.

Compliance with Laws and Regulations:

- Operate strictly in accordance with all applicable laws, regulations and standards.
- Ensure that all reports or other information required by any federal, state, or local government agency are filed timely, accurately and in conformance with the applicable laws and regulations.
- Promptly report any violations or suspected violations of any laws, regulations, policies, or procedures to a supervisor, director or the applicable Compliance Officer (CO).
- Not pay other healthcare professionals, directly or indirectly, to refer clients to any department.
- Not tolerate false or misleading statements, written or oral, by Covered Persons to a government agency or other payer.
- Not engage, either directly or indirectly, in any corrupt business practice including bribery, kick-backs, or payoffs, intended to induce, influence, or reward favorable decisions of any customer, contractor, vendor, governmental personnel or anyone in a position to benefit any department.
- Not engage in retaliation or reprisal against anyone who reports violations of law, regulations or agency policies.
- Limit the use and disclosure of confidential patient health information to the extent necessary to treat the patient/client/resident and to meet legal

requirements under HIPAA Laws and regulations and related State and Federal laws.

- Maintain all required professional licenses, certifications, or other credentials and comply at all times with federal and state requirements applicable to these professions.

Conflicts of Interest:

- Except upon the specific approval of the chief administrator, Director or Department, a Covered Person shall not accept personal gratuities or gifts from patients, clients, suppliers or vendors.
- Not become involved for personal gain with a client, vendor or supplier.
- Not engage in outside employment or activity which conflicts with Lewis County's interests or which reduces our effectiveness in performing our duties.
- Act in the best interest of Lewis County whenever dealing with vendors, suppliers or governmental agencies.
- Provide full disclosure and obtain clearance from the CCC and the Lewis County Ethics Board, if necessary, before engaging in any transaction involving the department where the Covered Person or the Covered Person's family member(s) receive any benefit, directly or indirectly.

Billing and Coding:

- Only bill for eligible services that are actually rendered, appropriately documented, and consistent with medical necessity guidelines.
- Take every precaution to ensure that our billing and coding work is accurate, timely and in compliance with our policies and federal and state laws and regulations.
- Not tolerate the submission of any claims which contain any false, fraudulent or inaccurate statements.
- Follow all established internal billing and coding protocols that may include establishing adequate separation of duties between care providers and fiscal staff; and comply with all internal controls that pertain to the functions of billing, collecting, recording, depositing, and reconciling funds.
- Ensure that the diagnosis and procedure codes reported on reimbursement claims are based on client's/patient's/resident's medical records as well as comply with applicable coding rules and guidelines.
- Promptly report any concerns regarding potentially erroneous billing or coding practices to our supervisor or the CO.
- Do not misrepresent the type or level of service rendered, bill for non-covered services, inappropriately unbundle services, bill for services rendered by other providers, or misrepresent a diagnosis in order to obtain higher payment.
- Not routinely waive deductibles or copayments without appropriate permission.

Business and Financial:

- Should represent the highest standards of business excellence.
- Handle all business and financial documents with integrity and accuracy.
- Retain all medical and business documents as required by law.
- Comply with financial accounting standards.
- Maintain computer passwords and access codes in a confidential and responsible manner.
- Keep accurate, true and complete records including business expense accounts, vouchers, bills, payrolls, service records, petty cash and reports, whether electronic or on paper.
- Establish, maintain, support and follow internal controls designed to provide reasonable assurance that transactions are authorized, and that transactions and other data are recorded and presented in a manner that is accurate, complete, current and not misleading.

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

I. FEDERAL LAWS

False Claims Act (31 USC §3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; ... or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus three (3) times the amount of damages which the Government sustains because of the act of that person...

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. 31 U.S.C. § 3729.

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, can also be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits a record that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a *qui tam* relator, when the Government has intervened in the lawsuit, shall receive at least fifteen (15) percent but not more than twenty-five (25) percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than twenty-five (25) percent and not more than thirty (30) percent.

Administrative Remedies for False Claims (31 USC Chapter 38. §§3801 - 3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to \$5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and

while most are specific to healthcare or Medicaid, some of the “common law” crimes apply to areas of interaction with the government.

A. CIVIL AND ADMINISTRATIVE LAWS

NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is \$6,000-\$12,000 per claim and the recoverable damages are between two (2) and three (3) times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit of 15-25% if the government did participate in the suit.

Social Services Law §145(b) - False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three (3) times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$2,000 per violation. If repeat violations occur within five (5) years, a penalty up to \$7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145(c) - Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for six (6) months if a first offense, twelve (12) months if a second (or once if benefits received are over \$3,900) and live years for four (4) or more offenses.

B. CRIMINAL LAWS

Social Services Law §145 - Penalties

Any person, who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law §366(b) - Penalties for Fraudulent Practices

- a. Any person who obtains or attempts to obtain, for himself or others, medical

assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

- b. Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Penal Law Article 155 - Larceny

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

- a. Fourth degree grand larceny involves property valued over \$1,000. It is a Class E felony.
- b. Third degree grand larceny involves property valued over \$3,000. It is a Class D felony.
- c. Second degree grand larceny involves property valued over \$50,000. It is a Class C felony.
- d. First degree grand larceny involves property valued over \$1 million. It is a Class B felony.

Penal Law Article 175 - False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

- a. §175.05: Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.
- b. §175.10: Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.
- c. §175.30: Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.
- d. §175.35: Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176 - Insurance Frauds

Applies to claims for insurance payment, including Medicaid or other health insurance and

contains six crimes.

- a. Insurance Fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
- b. Insurance fraud in the fourth degree is filing a false insurance claim for over \$1,000. It is a Class E felony.
- c. Insurance fraud in the third degree is filing a false insurance claim for over \$3,000. It is a Class D felony.
- d. Insurance fraud in the second degree is filing a false insurance claim for over \$50,000. It is a Class C felony.
- e. Insurance fraud in the first degree is filing a false insurance claim for over \$1 million. It is a Class B felony.
- f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177 - Health Care Fraud

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

Health care fraud in the fifth degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

- a. Health care fraud in the fourth degree is filing false claims and annually receiving over \$3,000 in aggregate. It is a Class E felony.
- b. Health care fraud in the third degree is filing false claims and annually receiving over \$10,000 in the aggregate. It is a Class D felony.
- c. Health care fraud in the second degree is filing false claims and annually receiving over \$50,000 in the aggregate. It is a Class C felony.
- d. Health care fraud in the first degree is filing false claims and annually receiving over \$1 million in the aggregate. It is a Class B felony.

III. WHISTLEBLOWER PROTECTION

Federal False Claims Act - 31 U.S.C. §3730(h)

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claim Act - State Finance Law §191

The False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and

conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority *as* the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law §740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

New York Labor Law §741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

IV. ANTI-KICKBACK LAWS

Federal Anti-Kickback Statute (42 USC 41320a-7b)

The Medicare/Medicaid Anti-Kickback Statute makes it a felony for any person or entity to knowingly and willfully solicit, receive, offer or pay any remuneration in exchange for referring, furnishing, purchasing, leasing or ordering (or recommending the furnishing, purchasing, leasing, or ordering of) any good, facility, service or item that is paid in whole or in part by the Medicare or Medicaid programs, or other federal health care programs. Both the recipient and the offeror of the remuneration are subject to the Anti-Kickback Statute. Violators are subject to fines up to \$25,000 per violation, up to five (5) years in prison, as well as administrative

penalties, including exclusion from participation in the Medicare and/or Medicaid programs.

Remuneration. The term “remuneration” is broadly defined and includes any kickback, bribe, discount, rebate, in cash or in kind, whether paid directly or indirectly. The government has taken the position that conferring of any benefit by one party on another constitutes “remuneration” for the purpose of the Anti-Kickback Statute. Because the prohibition applies to direct as well as indirect remuneration, the entire chain of financial transactions must be analyzed under this law where at least one of the parties receives reimbursement from federal health programs and at least one other party is in a position to make referrals, order goods or services or generate businesses for the first. Such common business practices as the provision of discounts for volume, or the offer of preferential pricing on prepackaged or bundled goods and services, are subject to scrutiny as unlawful remuneration.

One Purpose Rule. The Anti-Kickback Statute has been construed by court decision to prohibit any otherwise legitimate remuneration for goods or services rendered if “one purpose” of the payment is to induce the referral, furnishing, leasing, etc., of goods or services paid by the Medicare or Medicaid programs.

Fair Market Value. When the remuneration between the parties is not fair market value, the government suspects that one purpose of the reimbursement is to compensate referrals between the parties.

Fair market value under the Anti-Kickback Statute is generally defined as that remuneration in an arms’ length transaction that is not determined in a manner that takes into account the volume or value of Medicare or Medicaid services generated between the parties. Although no compensation methodology is per se prohibited, the government in various public statements has indicated that it views per procedure, per order, per purchase and percentage of revenue compensation methodologies as susceptible to abuse under the Anti-Kickback Statute because they inherently vary with volume or value.

Safe Harbors. The government has promulgated by regulation certain “safe harbors,” which are payment practices that are excluded from the definition of “remuneration.” However, the failure of an activity to comply with a safe harbor does not mean it violates the law, only that it is subject to case by case scrutiny under the Anti-Kickback Statute. The safe harbors cover a limited number of payment practices and are narrowly drawn. In all cases the safe harbors require arrangements to be in writing and remuneration to be fair market value. In addition, the safe harbors generally require that the entire transaction be “commercially reasonable” and have a reasonable commercial purpose other than the exchange of referrals. The risk of an enforcement action is mitigated the closer a transaction comes to meeting the various standards of a safe harbor.

Fraud Alerts. The Office of Inspector General (OIG) of the Department of Health and Human Services in fraud alerts, Advisory Opinions and other public statements has identified practices and arrangements that it considers potentially violative of the Anti-Kickback Statute. These fraud alerts should be regarded as the government’s enforcement position with respect to a particular subject matter. The fraud alerts are examples and the naming of specific types of providers in a fraud alert does not limit the application of its meaning.

The OIG considers improper under the Anti-Kickback Statute any payment, prize, reward, including any gift, or any offer of free goods or services if it is:

- made to a person in a position to generate business for the paying party related to the volume of business generated for the paying party;
- is more than nominal in value and/or exceeds fair market value of any legitimate service rendered to the paying party, or is unrelated to any service at all other than generation of business for the paying party.

Because of the central role of physicians under Medicare reimbursement rules, the OIG has also issued fraud alerts on the paying of incentives to physicians, and has identified several arrangements it considers potentially improper, such as providing physicians with:

- free or significantly discounted office space, equipment or staff;
- free training for physician's office staff;
- discounted loans or loan forgiveness tied to patient referrals;
- conference and/or continuing education expense reimbursement;
- insurance coverage at a below-standard cost;
- payment for services requiring few actual duties;
- a discounted price or a gift, coupon, bonus or cash payment to physicians in exchange for or based on prescribing or ordering specific products;
- cash or other benefits in exchange for performing sales-oriented, educational or patient outreach marketing; and in-office technicians, computers and/or fax machines at no charge, unless it can be shown that the staff or equipment is integral to the service being provided by the supplier, and limits are placed and monitored to assure staff and equipment are used by physicians only for the purposes of using or ordering the supplier's product.

V. FEDERAL STARK LAW. 42 USC §1395nn.

Under the federal physician self-referral prohibition (known as the Stark Law), a physician is prohibited from referring to an entity for certain “designated health services” if he or she has an ownership interest or a compensation arrangement with the entity. In addition, the referral recipient is prohibited from submitting a claim or receiving payment for services provided pursuant to a prohibited referral. Because a “compensation arrangement” is defined as one which involves any form of remuneration, direct and indirect, the Stark Law will apply to every financial relationship between an entity and a physician, and likely such intermediaries and Internet based service providers who facilitate transactions between the physician and the provider of designated health services. “Designated health services” include outpatient prescriptions and radiology services.

The Stark Law differs from the federal Anti-Kickback Statute in that where the Anti-Kickback Statute is intent-based (i.e., it requires knowing and willful behavior); the Stark Law creates an absolute prohibition on referral regardless of intent unless the financial relationship or the referral falls within a stated exception. Hence, failure to find an exception to the Stark Law is generally fatal to a transaction. One of the exceptions provided under Stark is for the purchase of services (other than designated health services) by a physician at fair market value. This exception would apply to the financial relationship between an Internet based services provider and a physician.

All Covered Persons must fill out the acknowledgment form on the following page.

LEWIS COUNTY

ACKNOWLEDGEMENT

I certify that I have received the Corporate Compliance Plan adopted September 7, 2010, which includes the Health Services Code of Conduct. I understand that it is a mandatory policy and I agree to abide by it.

Signature

Printed name

Date