ADIRONDACK HEALTH
Better Health, Better Lives

ADIRONDACK HEALTH

CORPORATE COMPLIANCE PLAN

2023

Approved
Board of Trustees
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INTRODUCTION

As a not-for-profit, tax-exempt healthcare provider licensed in New York State, Adirondack Health (AH) is committed to operating in an ethical and moral manner and ensuring that the organization, in all of its activities, complies with applicable state and federal laws, regulations, guidelines, and standards. The purpose of this Corporate Compliance Plan (Plan) is to describe AH's program for detecting and preventing fraud, waste and abuse and ensuring compliance with federal and state laws, regulations, guidelines and standards (Corporate Compliance Program).

The Corporate Compliance Program is overseen by the Adirondack Health Board of Trustees ("Board of Trustees") to assure that the scope and operation of the Compliance Program are appropriate and that the Compliance Program is effective. This Plan is operationalized in conjunction with the Adirondack Health Code of Conduct and other AH policies and procedures. In carrying out this Plan, AH adheres to the precepts of a Just Culture, encouraging conduct that is honest, open and in the best interest of AH, its patients, residents and community.

This Plan is applicable to all of AH's operations, including but not limited to the following:

- Billings
- Payments
- Medical necessity and quality of care
- Governance
- Mandatory reporting
- Credentialing
- Other risk areas identified by the Compliance Officer

Together with the Code of Conduct, this Plan provides standards by which all individuals who are affected by AH's risk areas will conduct themselves, including the Board of Trustees, employees, the President/CEO, Senior Management, administrators, managers, members of the medical staff and associate medical staff (collectively, "Medical Staff"), students, residents, volunteers, contractors (including independent and subcontractors), and agents (collectively, Affected Individuals). "AH" as used in this Plan refers to all facilities, units, departments and clinics operated by AH or Adirondack Health Regional Medical, P.C., regardless of location.

This Plan is organized around the seven fundamental elements of an effective compliance program required by New York's Mandatory Compliance Program for Medicaid providers (Social Services Law §363-d), as well as the elements described by the United States Office of the Inspector General (OIG) voluntary compliance program guidance documents) and the US Sentencing Guidelines as essential to an effective Compliance Program:

1. Implementing written policies and procedures and standards of conduct;
2. Designating a compliance officer and compliance committee;
3. Establishing and implementing compliance program training and education;
4. Establishing and implementing lines of communication and ensuring confidentiality;
5. Establishing and implementing disciplinary standards and encouraging good faith participation;
6. Establishing and implementing routine auditing and monitoring and identification of compliance risks; and
7. Establishing and implementing procedures/system for responding promptly to, investigating, and correcting compliance issues, and ensuring ongoing compliance with federal and state requirements (including Medicaid).

I. WRITTEN POLICIES & PROCEDURES - Compliance Standards

AH is subject to numerous federal and state laws and regulations that govern its activities. These laws and regulations include, but are not limited to, the fraud and abuse and other compliance-related laws shown on Exhibit A. Affected Individuals are expected to be knowledgeable of, and in compliance with, those laws and regulations affecting their area of responsibility. Affected Individuals who intentionally violate laws or regulations risk individual criminal prosecution, civil actions for monetary damages and exclusion from working in connection with federally funded health care programs. In addition, actions of Affected Individuals may subject AH to the same risks and potential penalties. Accordingly, all Affected Individuals are expected to comply with all applicable state, federal and local laws, regulations, guidelines and standards, the policies and procedures of AH and recognized corporate accountability practices. Any Affected Individual who violate any of the foregoing, including this Plan, may be subject to disciplinary action, up to and including termination of their employment/affiliation.

Expected standards of conduct are included in the terms and conditions of employment as well as the yearly performance appraisals of each employee of the organization. Should Affected Individuals question the business integrity of any individual or department of this organization, they are expected to report their concerns, anonymously if so desired, in accordance with Part IV of this Plan.

Policies and Procedures

AH's compliance standards include all approved policies and procedures that have been developed throughout the organization, as well as those that have been developed in accordance this Plan. This Plan and the policies and procedures directly referred to in this Plan are specific to the mission and vision, lines of business and corporate culture of AH. All policies related to the Compliance Program are available to all Affected Individuals on AH's Intranet.

AH's compliance policies, procedures and standards of conduct address the following:

- AH's commitment to comply with all federal and state standards;
- Compliance expectations as embodied in the standards of conduct;
- Implementation of the Compliance Program;
- Guidance on dealing with potential compliance issues;
- Methods for communicating compliance issues to the Compliance Officer and others;
- Process for investigating and resolving potential compliance issues;
- AH's 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, conducting self-evaluations, audits and remedial actions, and report to appropriate officials; and
- Implementation of the requirements of the 2005 Deficit Reduction Act, including detailed information about federal and state laws addressing false claims and whistleblower protections and AH's policies and procedures addressing the same.

On an annual basis, this Plan and related compliance policies, procedures and standards of conduct are reviewed by the Compliance Officer and Corporate Compliance Committee to determine if (i) they have been implemented, (ii) whether Affected Individuals are following them, (iii) whether they are effective, and (iv) whether any updates are required. Any changes are approved by either the Board of Trustees or Senior Management, as appropriate. Protocols and policies that further define the Program activities will be maintained by the Corporate Compliance Officer and Corporate Compliance Committee. These will include but not be limited to protocols for day-to-day operations of corporate compliance, audits and reviews, and oversight of departmental policies relating to corporate compliance.

Corporate compliance policies and procedures shall be disseminated and/or made available to all Affected Individuals as further described below.

Code of Conduct

The AH Code of Conduct is a foundational document that describes AH's fundamental principles and values, and commitment to conduct its business in an ethical manner. Affected Individuals are responsible for ensuring that their behavior and activities are consistent with this Code of Conduct, along with any additional codes of conduct that may apply as a departmental or professional standard, and are expected to refuse to participate in unethical or illegal conduct and to report any unethical or illegal conduct to the Compliance Officer.

AH, through the Compliance Officer, Corporate Compliance Committee, Senior Management or Human Resources, may expand these guidelines through the development of policies and procedures that address specific issues and activities that need additional clarification or have been identified as compliance risk areas.

Code of Ethics

The AH Code of Ethics includes the Mission Statement, Vision Statement, Guiding Principles, and Employee Philosophy, which detail essential ethical behavior. These statements and principles direct Affected Individuals to provide services, including public relations/marketing, admissions, transfer and discharge and billing practices, in a manner that builds patient, resident and family trust, encourages open and honest communication, honors confidentiality and privacy, displays excellence and competence, and provides education as appropriate.

All Affected Individuals shall be treated with respect. Their cultures and religious traditions, as well as the dignity of their work shall be recognized. They shall be provided a safe and secure environment as well as the resources needed to meet our mission.

AH will at all times maintain professional and ethical standards in the conduct of its business. Affected Individuals are expected to understand and adhere to the ethical standards as required by the Affected Individual's position or profession and as defined by AH's mission, vision, values and policies relating to the Code of Conduct. AH requires honesty from all Affected Individuals in the performance of their duties and in communication with all outside parties. Affected Individuals shall not knowingly make false or misleading statements to any person or entity doing business with AH.

Business transactions undertaken on behalf of AH shall at all times be free from offers or solicitations of gifts or other improper inducements in exchange for influence on or assistance with the transaction. Offering, giving, soliciting or receiving any form of bribe or illegal inducement is expressly prohibited. Acceptance of gifts outside of policy guidelines will subject the Affected Individual to discipline, up to and including termination of employment or ending their association with AH.

AH will manage and operate its business in a manner that respects the environment and conserves natural resources. Affected Individuals will utilize AH resources wisely, recycle when possible and otherwise dispose of waste in accordance with applicable laws and regulations.

A violation of the Code of Conduct or the Code of Ethics is considered a violation of AH's Compliance Program.

Not-for-Profit Corporation Law and Tax-Exemption Compliance

AH is a New York State not-for-profit corporation and derives substantial benefit from exemptions from Federal income taxes pursuant to IRC § 501(c)(3) and State and local franchise, sales and real property taxes, as well as the ability to receive tax-deductible donations. Compliance with all laws and regulations applicable to its not-for-profit, tax-exempt status is fundamental to achieving AH's mission.

New York's Not-for-Profit Corporation Law requires, among other things:

- AH must operate in furtherance of its charitable purposes, as set forth in its Certificate of Incorporation.
- All profits must be applied to the maintenance, expansion or operation of AH's lawful activities.
- Purchases, sales, mortgages, leases, exchanges or other disposition of real property require the approval of the Board of Trustees or a committee authorized by the Board.
- AH may pay reasonable compensation for services rendered. No person who receives compensation may be present at, participate in discussions or vote concerning such compensation.
- Institutional funds (i.e., donations and the earnings thereon) must be invested and managed in accordance with the Prudent Management of Institutional Funds Act, Article 5-A of the Not-for-Profit Corporation Law.
- The Board or a designated audit committee comprised solely of independent Trustees must annually engage AH's independent auditor, and oversee the accounting and financial reporting processes of AH and the audit of its financial statements. The Board has delegated this authority to its Audit and Compliance Committee, the responsibilities of which are set forth in AH's Bylaws.
- AH must have a Conflict of Interest Policy and a Whistleblower Policy.
- AH may not enter into any related party transaction unless the transaction is determined by the Board to be fair, reasonable and in AH's best interest. The process for making this determination is set forth in AH's Conflict of Interest Policy.
- AH may not make loans to its Trustees or Officers or to any corporation, firm, association or other entity in which one or more of Trustees or Officers are directors or officers or hold a substantial financial interest, with the exception of purchases made through public offerings, ordinary bank deposits, or loans to another charitable corporation.

To maintain its tax-exempt status, AH must, among other things:

- Be organized and operated exclusively for tax-exempt purposes: AH will be regarded as operated exclusively for exempt purposes only if it engages primarily in activities that accomplish an exempt purpose specified in § 501(c)(3) and no more than an insubstantial part of its activities is in furtherance of a non-exempt purpose.
- Not permit its net earnings to inure to the benefit of any private individual/insider (such as Trustees, Officer, senior management or other persons with substantial influence over the operations of AH);
- Operate in accordance with all applicable laws and regulations; and
- File IRS Form 990 annually and comply with all other reporting requirements.

Corporate Compliance Risk Areas

Issues addressed through this Plan will involve unethical conduct and/or conduct that does not comply with State and Federal laws, regulations and guidelines. This includes issues where this Plan has oversight of AH's policies or protocols. Issues that are not related to ethics, State or Federal laws and oversight by this Plan will be referred to Senior Management and/or the appropriate committee for review and resolution.

Various fraud and abuse laws exist and explain in detail activities that are illegal. As part of the Compliance Program, these areas of risk are monitored on an on-going basis and include, but are not limited to, the following activities if performed by AH:

- Billing for services not actually rendered;
- Misrepresenting services which were rendered;
- Making false statements to governmental agencies about AH's compliance with any state or federal rules;
- Falsely certifying that services were medically necessary;
- Accepting payments in excess of applicable federal or state healthcare program established rates;
- "Upcoding," utilizing a code to bill for a higher level of service then was rendered, thus resulting in an increase in reimbursement rate;
- Failing to refund overpayments made by a Federal or State healthcare program;
- Violating the terms of a participating physician agreement;
- Anti-Kickback regulation violations;
- Violating regulations on referrals of patients due to ownership or financial relationship;
- Billing for an item or service that was not provided, was fraudulent, or was not medically necessary;
- Compensating someone for receiving items or services that are billed to a third party;
- Defrauding any healthcare benefit program;
- False Statement and False Claims;
- Criminal False Statements related to health care;
- Double billing;
- Unbundling of charges that should remain together;
- Theft or Embezzlement in connection with health care;
- EMTALA violations, inadequate screening and stabilization prior to transfer;
- HIPAA violations, failure to maintain confidentiality of health care records;
- Failure to follow the AH Code of Conduct; and
- Accepting gifts that are not within policy guidelines or are unethical.

II. COMPLIANCE PROGRAM STRUCTURE

The Board of Trustees has affirmed its commitment to maintaining AH's operations in compliance with all Federal and New York State laws and regulations by approving the Corporate Compliance Plan and Compliance Program and by designating a Compliance Officer and Corporate Compliance Committee to maintain an effective compliance program. Exhibit B presents an organizational chart for the Compliance Program.

Corporate Compliance Officer (Compliance Officer)

The Compliance Officer is the focal point for AH's Corporate Compliance Program and is responsible for its day-to-day operations. With the support of the Corporate Compliance Committee, the Compliance Officer administers and manages all tasks related to maintaining, monitoring and updating the Corporate Compliance Program. This includes the authority to (a) access all relevant records, documents, information facilities, and Affected Individuals that are relevant to carrying out the Compliance Officer's responsibilities, (b) develop and maintain policies and procedures, and (c) institute activities needed to maintain the Program. AH will ensure that the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform the Compliance Officer's responsibilities for the day-to-day operation of the Program based AH's risk areas and organizational experience.

The Compliance Officer reports directly and is accountable to the President/CEO. The Compliance Officer periodically reports to the Board of Trustees. A direct line of communication exists to the Chair of the Board of Trustees as well as to the President/CEO. At any time, the Compliance Officer may present compliance issues to the Chair of the Board of Trustees without approval from or notice to Senior Management.

The Corporate Compliance Officer's responsibilities include, but are not limited to:

Policies, Procedures and Standards of Conduct

- Overseeing and monitoring the adoption, implementation and maintenance of the Program and the Plan and evaluating its effectiveness, which includes the following activities.
- Revising and/or developing new compliance policies and procedures and standards of conduct to meet the ongoing needs of the Program to ensure they meet the intent of regulators and the Plan and that they encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.
- Reviewing (and revising as necessary) the Corporate Compliance Plan and related policies, procedures and standards of conduct annually to determine their effectiveness and updating or revising in light of this evaluation and changes in AH's needs, changes in the law, and changes in the policies and procedures of government and private payor health plans.
- Drafting, implementing, and updating no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rule, regulations, policies and standards, a Compliance Work Plan, which outlines AH's proposed strategy for meeting the requirements of the Plan for the upcoming year.
- Assisting AH in establishing methods to improve AH's efficiency, quality of services, and reducing AH's vulnerability to fraud, waste and abuse.

Compliance Committee and Board of Trustees

- Chairing the Corporate Compliance Committee and bringing recommendations to the Committee regarding standards and criteria relevant to compliance issues.
- Reporting directly, on a regular basis, but no less frequently than quarterly to the Board of Trustees, President/CEO, and Compliance Committee on the progress of adopting, implementing, and maintaining the compliance program.;

Compliance Program Training and Education

- Providing oversight on applicable compliance standards for the training and education of all personnel and agents involved in the clinical and billing/coding areas of AH.
- Ensuring that all Affected Individuals receive training and education upon hire/appointment and at least annually thereafter in the basic principles of corporate compliance and ethical business practices.
- Developing, coordinating and participating in a multi-faceted educational and training program and plan that focuses on the elements of the Compliance Program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent Federal and State standards.
- Ensuring that independent contractors and agents who furnish medical services to AH are aware of the requirements of AH's Corporate Compliance Program with respect to coding, billing and marketing, among other things.

Lines of Communication

- Answering inquiries related to corporate compliance issues.
- Implementing and maintaining a system of confidential compliance concern reporting options that encourage Affected Individuals to report compliance concerns without fear of retribution, including (1) the Compliance Form on the SafetyZone portal; (2) the Compliance Telephone Hot Line and (3) the Compliance Officer's email.

- Establishing and maintaining open lines of communication with all departments and services, to ensure effective and efficient communication about compliance policies and procedures.

Disciplinary Standards

- Coordinating personnel issues with AH's Human Resources office to ensure that [the National Practitioner Data Bank and Cumulative Sanction Report] have been checked with respect to all employees, Medical Staff and independent contractors.

Auditing and Monitoring

- Serving as a resource to those who are performing audits and monitors related to financial issues, and quality compliance matters.
- Working closely with all regulatory body auditors and the annual AH external auditor.
- Assisting AH's financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments.
- Working closely with the CMO, Director of Patient Financial Services, the Director of HIM and others as appropriate regarding physician and clinical staff credentialing, scope of privileges, documentation, coding and billing issues.
- Monitoring credentialing and conducting monthly checks of the Federal and State exclusion lists.
- Working with the certifying official identified in the annual SSL certification(s) to ensure accurate completion of the certification on OMIG's website.
- Overseeing self-disclosures and refunding of overpayments.

Responding to Compliance Issues

- Receiving, independently investigating, and acting on compliance concerns and violations.
- Designing, coordinating and overseeing the implementation of internal investigations needed to respond to reports of problems or suspected violations.
- Documenting, reporting, coordinating, and pursuing any resulting corrective actions when indicated with all AH departments, providers, agents, independent contractors, and New York State.

Corporate Compliance Committee

The Corporate Compliance Committee coordinates with the Compliance Officer in overseeing, administering and managing the Compliance Program, including implementing all compliance policies and procedures in accordance with the Corporate Compliance Plan. The Committee is responsible for coordinating with the Compliance Officer to ensure that AH is conducting its business in an ethical and responsible manner, consistent with the Plan. The Committee reports directly and is accountable to the President/CEO and the Board of Trustees. The Compliance Officer shall chair the Committee.

Committee responsibilities include but are not limited to:

- Analyzing legal requirements, identifying compliance risk areas and making recommendations accordingly;
- Developing standards, strategies, protocols, policies and procedures to address compliance concerns;
- Making recommendations related to education on corporate compliance and ensuring the required training topics are timely completed;
- Recommending monitors and audits to evaluate compliance concerns and recommending re-audits of items where there is risk for recurrence of problems;
- Monitoring the results of external and internal investigations and reviews (e.g., OIG, OMIG RAC, QIO's, and reviews by independent Auditors);
- Supporting the Corporate Compliance Officer.

- Coordinating with the Compliance Officer to ensure the Plan and related policies and procedures, and code of conduct are current, accurate, complete, and effective.
- Coordinating with the Compliance Officer to ensure communication and cooperation by Affected Individuals on compliance related issues, internal or external audits, and other required functions or activities necessary for an effective Program.
- Advocating for the allocation of sufficient funding, resources and staff for the Compliance Officer to fully perform their responsibilities.
- Ensuring that AH has effective systems and processes in place to identify compliance program risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues.
- Advocating for the adoption and implementation of required modifications to the Program.
- Reviewing and updating the Compliance Committee charter on an annual basis.

The Committee's membership includes the Corporate Compliance Officer, President and CEO, senior leadership, Board liaison, and others, including but not limited to, representatives from finance, IT, revenue cycle, HIM/coding, case management, patient care services, pharmacy, medical staff, quality, human resources, and others as required to effectively carry out the work of the Committee.

The Chair of the Committee is the Compliance Officer.

Meetings shall be held on a quarterly basis or more frequently if needed. Attendance may be in person or by secure remote connection. All members of the Committee are eligible to vote. A quorum of six members is required to conduct a business meeting.

Board of Trustees

The Board is ultimately responsible for the operation of AH and the conduct of its employees and Medical Staff. In order to carry out its oversight responsibilities and leadership position, the Board undertakes the following compliance activities:

- The Board has delegated oversight of the Compliance Program to the Audit and Compliance Committee of the Board. Both the Compliance Officer and the Corporate Compliance Committee report directly to and are accountable to the Audit and Compliance Committee.
- The Board, through the Audit and Compliance Committee of the Board, will annually review the implementation and execution of the Compliance Program elements and determine (i) if the Plan, related policies and procedures, and standards of conduct have been implemented, (ii) whether Affected Individuals are following the policies, procedures, and standards of conduct, (iii) whether such policies, procedures, and standards of conduct are effective; and (iv) whether any updates are required.
- The Board, through the Audit and Compliance Committee of the Board, will annually assess (i) whether the Compliance Officer able to satisfactorily perform the Compliance Officer's responsibilities despite other job duties, (ii) whether the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform the Compliance Officer's responsibilities based on AH's risk areas and organizational experience, and (iii) whether the Compliance Officer and compliance personnel have access to all records, documents, information, facilities, and Affected Individuals related to carrying out their responsibilities.
- The Board will receive annual and periodic education and in-service training on compliance issues, expectations and Compliance Program operation, as well as the Board's role as the governing body of a health care institution, evolving guidelines and standards relating to governance, and recommended best practices.
- At least three times a year, the Compliance Officer will provide a written report to the Audit and Compliance Committee of the Board on compliance activities, including complaints, external investigations and audits, the results of assessments, corrective steps and actions to reduce recurrences.

- Assessments may include examination of billing and coding issues, mandatory reporting laws and quality improvement matters that involve compliance with laws or regulations. Other staff may assist the Compliance Officer in making these reports to the Board.
- The full Board will be provided with an annual Corporate Compliance Report, which summarizes the compliance activities, including complaints, external investigations and audits, the results of assessments, corrective steps and actions to reduce recurrences for the applicable calendar year, and the goals for the following year.

The President/CEO

The President/CEO oversees the Compliance Officer and Compliance Committee, both of which report directly to and are accountable to the President/CEO. As a result, the President/CEO:

- Meets regularly with the Corporate Compliance Officer;
- Reviews and recommends to the Board the approval of the Compliance Program and Plan;
- Stays aware of and informed on important compliance investigations, initiatives, issues and resolutions;
- Supports the efforts of the Compliance Program and promotes accountability throughout AH;
- Provides guidance and support to the Compliance Officer and Corporate Compliance Committee;
- Ensures sufficient resources (training, budget, staffing) to the Compliance Program to ensure its effectiveness.

HIPAA Privacy Officer

- Performs work, including gap analyses and risk assessments, to determine necessary development or revisions of organizational policies and procedures, education or re-education needs and makes recommendations that will address compliance concerns;
- Monitors current information and data flow (use and disclosure) of protected health information within and between departments and programs including exchanges with contract providers, vendors and others;
- Reviews business associate agreements (BAA's) to ensure all privacy and security concerns, requirements, and responsibilities are addressed; retains these documents in an accessible location;
- Acts as a resource for departments and provides education on HIPAA and HITECH requirements;
- Holds a lead role in the development and maintenance of privacy and security awareness training relevant to HIPAA HITECH compliance issues for all appropriate employees;
- Establishes and administers formal processes for receiving, investigating, taking action on, and documenting all privacy complaints in coordination with others including Department Directors, the Corporate Compliance Officer and Director of Human Resources;
- Enforces appropriate sanctions for employees who fail to comply with AH's HIPAA HITECH policies and procedures in collaboration with Department Directors and Human Resources;
- Cooperates with the Department of Health and Human Services Office for Civil Rights and other officials during any compliance reviews or investigations of alleged breaches of privacy policy and procedures. This includes performing a risk assessment to determine when a breach is reportable and notifying the Secretary of HHS per policy;
- Prepares and submits quarterly written Privacy Officer Reports to the Corporate Compliance Committee;
- Serves on the Corporate Compliance Committee.

HIPAA Security Officer

- Responsible for developing, implementing, and accurately maintaining appropriate policies and procedures that support the HIPAA security requirements;

- Monitors and analyzes security alerts and other security communications and ensures adequate follow-up;
- Conducts security risk assessments;
- Investigates security incidents/breaches and ensures adequate follow-up; provides summary reports of these activities to the Corporate Compliance Committee;
- Establishes, manages and enforces the HIPAA/HITECH Security Rule safeguards and subsequent rules issued by OCR related to HIPAA security;
- Addresses issues related to access controls, business continuity and disaster recovery;
- Serves on the Corporate Compliance Committee.

AVP's, Directors, Managers and Supervisors

Members of management are accountable for understanding and abiding by the laws and regulations that apply to their areas of responsibility. They will develop and implement internal controls to provide reasonable assurance that the Affected Individuals they supervise comply with laws and regulations. They will maintain compliance with the Corporate Compliance Plan and report non-compliance. In addition, they will work with the Compliance Officer and Corporate Compliance Committee in addressing concerns and issues to assure maintenance of legal, moral and ethical standards and fully cooperate and assist the Compliance Officer in the performance of the Compliance Officer's duties.

Employees, Medical Staff and Associate Staff

As an integral part of providing services, all AH employees and all members of AH's medical and associate staff will maintain compliance in the following manner:

- Abide by all applicable laws, Medical Staff and Adirondack policies, procedures, guidelines, protocols, rules and regulations and agreements as well as their own professional standards;
- Report any information relating to unlawful or unethical activities including fraud waste and abuse to an immediate supervisor, Department Director, President/CEO or Corporate Compliance Officer. Reports may made by telephone, US Mail, interoffice mail, in person, or via Safety Zone's Corporate Compliance Form;
- Report their own errors or misconduct without fear of retribution, so AH can assist in correcting these and minimize impact on operations;
- Know that failure to report known violations shall be grounds for disciplinary actions including termination of reemployment or affiliation;
- Participate in education on corporate compliance when hired and annually thereafter;
- Know that employees are protected under "whistle blower protections" provided by the federal false claims act (31 U.S.C. §3730 (h)) and NYS False Claim Act (State Finance Law §191). Reference is made the AH Whistleblower Policy (CC004);
- Fully cooperate and assist the Compliance Officer as outlined in the performance of his or her duties. Any uncertainty regarding compliance issues should be brought to the attention of the Compliance Officer for assistance and direction.

Volunteers, students, and independent contractors/vendors will be held to the same standards.

III. EDUCATION AND TRAINING

AH will provide appropriate educational training programs and resources to ensure Affected Individuals have familiarity with organizational policies and procedures and those areas of law that affect the conduct of their job duties. Affected Individuals will also receive specific compliance training and education about compliance issues, compliance expectations and the operation of the Compliance Program applicable to their role with AH.

This training will introduce Affected Individuals to compliance to help them understand the subject and AH's commitment to an ethical, professional work environment and compliance with legal standards.

Such education will include the following core topics:

- AH's risk areas and organizational experience;
- AH's Compliance Plan and written compliance policies and procedures;
- The role of the Compliance Officer and Corporate Compliance Committee;
- How Affected Individuals can ask questions and report potential compliance-related issues to the Compliance Officer and senior management, including the obligation of Affected Individuals to report suspected illegal or improper conduct and the procedures for submitting such reports, and the protection from intimidation and retaliation for good faith participation in the Compliance Program;
- Disciplinary standards, with an emphasis on those standards related to AH's Compliance Program and prevention of fraud, waste and abuse;
- How AH responds to compliance issues and implements corrective action plans;
- Requirements specific to the Medicaid program and AH's category or categories of service;
- Coding and billing requirements and best practices, if applicable;
- Claim development and the submission process, if applicable.

The responsibility for the development of compliance training and education lies with the Compliance Officer and Corporate Compliance Committee, with the assistance of Employee Education and Department Directors.

For Affected Individuals who are employed by AH , Corporate Compliance will be explained when first hired during orientation, which will occur promptly upon hiring. At a minimum, compliance education and training will thereafter be provided annually to all employed Affected Individuals (including the Compliance Officer, President/CEO and other Senior Management and managers). Additional department specific and/or organization-wide compliance education may be provided as needs arise. Participation in routine new employee orientation education and annual training will be monitored by the Employee Education Office.

New members of the Board of Trustees will receive compliance training and education as part of their Board orientation and the entire Board of Trustees will receive compliance training and education at least annually. Newly appointed members of the Medical Staff will be provided with the HHS-OIG publication "A Roadmap for New Physicians" as well as an overview of the Compliance Program's core topics, and all Medical Staff will receive compliance training and education at least annually.

Volunteers, students, and independent contractors performing services in AH's identified risk areas will receive training and education similar to employees upon affiliation with AH and thereafter annually.

All Affected Individuals need not have the identical amount of training and education, nor should the focus of training and educational efforts be the same, so long as all Affected Individuals receive training in the core topics listed above. The actual amount of training should reflect necessity, an analysis of risk areas, areas of concern identified by AH or a regulatory oversight agency, and the results of periodic audits or monitoring. Affected Individuals may receive job or departmental specific compliance education at the discretion of their Department Director or at the request of the Corporate Compliance Committee. Targeted education will focus on technical and functional training to allow staff to carry out their job responsibilities in a fully compliant manner. This could include but is not limited to:

- Training and education for employees who obtain the necessary demographic, insurance, and other information to support proper application of the discharge appeal process, advanced beneficiary notification, Medicare as secondary payer, and the 72-hour rule;

- Training that increases Affected Individuals ability to correctly document and maintain accuracy affecting claim submission including medical necessity considerations, confidentiality of patient information, appropriate discharge status;
- Training that establishes accuracy related to charging to prevent inappropriate bundling/unbundling along with accuracy of procedure documentation, and charge capture;
- Training to assure correct coding, confidentiality, and record retention;
- Accuracy in claim composition, credit balance reporting and disposition, billing only for items and services actually rendered, and avoiding duplicate billing;
- Training for those responsible for cost reports, disposition of credit balances, charity and bad debt policies and requirements, graduate medical education requirements, and tax-exempt status;
- Management training could include courses related to prohibited provider relationships such as anti-kickback, Adirondack Health/physician relationships, joint ventures, and anti-trust laws.

Compliance training and educational programs may utilize a variety of teaching methods and will be customized to the targeted groups recognizing the skills, experience, knowledge and educational level. In addition, such training and educational programs will be provided in a form and format that is accessible and understandable to all Affected Individuals, consistent with Federal and State laws, rules or policies.

All compliance educational sessions will allow time for questions and answers or provide directions on contacting the Corporate Compliance Officer to address questions. Outside experts may be enlisted to conduct specialized or highly technical compliance training.

The educational material provided to Affected Individuals is to include whistle blower provisions and protections clearly identifying that employees are protected under "whistle blower protections" provided by the federal False Claims Act (31 U.S.C. §3730 (h)) and NYS False Claim Act (State Finance Law §191). These include:

Federal False Claims Act (31 U.S.C. §3730(h))
The Federal Claims Act provides protection to *qui tam relators* (whistleblowers) 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* (whistleblowers) 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.

Specific statutory and regulatory provisions listed in section 1902(a)(68)(A) of the Social Security Act and other applicable state civil or criminal laws and state and federal whistleblower protections along with information regarding AH's policies and procedures for detecting and preventing waste, fraud, and abuse will be noted.

The Compliance Officer will develop and maintain a compliance training plan. At a minimum, the training plan will outline the subjects or topics for training and education, the timing and frequency of the training, which Affected Individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated.

IV. COMMUNICATION AND REPORTING

Affected Individuals have a duty and obligation to immediately report any suspected or actual violation of laws, regulations, standards or any other part of this Plan. To encourage such reporting, AH has several different lines of communication that ensure confidentiality and anonymity, if requested, when making such reports.

The Compliance Officer has an open-door policy regarding reports of violations or suspected violations of the law or questions concerning adherence to the law and components of the Plan. To encourage reporting of compliance concerns or questions, AH has a Compliance Hotline to the Corporate Compliance Officer's telephone. The telephone number is located in the Adirondack Medical Telephone Directory under "Corporate Compliance." This telephone number is attached to a secured voice mail system accessible only by the Compliance Officer. *Calls to the Compliance Hotline may be made anonymously*.

In addition to telephone reporting, Affected Individuals may make a written report, use electronic mail, make a compliance concern report in person, or via the SafetyZone Corporate Compliance Form. If the Compliance Officer is unavailable and an Affected Individual is uncomfortable making a report to their supervisor, they should contact the President/CEO or the administrator on call.

Affected Individuals may also call the hotline of the Office of Inspector General of the Department of Health and Human Services at 1-800-HHS-TIPS (1-800-447-8477) or https://forms.oig.hhs.gov/hotlineoperations/report-fraud-form.aspx. Affected Individuals may also reach the New York State Office of the Medicaid Inspector General at 1-877-87-FRAUD (I-877-873-7283) or https://omig.ny.gov/index.php/fraud/file-an-allegation.

AH patients, including Medicaid recipients of service, may also use any of the foregoing methods of reporting to report compliance concerns.

Affected Individuals are encouraged to disclose their identity, recognizing that anonymity may hamper complete and timely investigations. However, anonymous reports will not be refused or treated less seriously because the reporter wishes to remain anonymous.

AH shall maintain the confidentiality of persons reporting compliance issues to the fullest extent possible, unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, Medicaid Fraud Control Unit, Office of Medicaid Inspector General or law enforcement, or disclosure is required during a legal proceeding. Such persons shall be protected under AH's policy for non-intimidation and non-retaliation.

AH prohibits any Affected Individual from retaliating against or engaging in harassment, intimidation or discrimination of any individual (including Medicaid recipients of service and all other AH patients) who has reported suspected wrongdoing, reported potential issues, investigated issues, engaged in self-evaluations, audits and remedial actions, or any other good faith participation in the Compliance Program. Every supervisor and manager has the responsibility to create a work environment in which ethical and legal concerns can be raised and openly discussed without fear of retaliation or retribution. This includes avoiding any action that might constitute retaliation, retribution, intimidation, discrimination or harassment against an employee who has reported a concern.

No Affected Individual who reports a compliance concern will be retaliated against or otherwise disciplined solely for reporting the concern. Affected Individuals found to have retaliated against another Affected Individual will be disciplined in accordance with disciplinary guidelines or Medical Staff by-laws up to and including termination.

This Plan does not provide protection or immunity from disciplinary action or prosecution to individuals who have engaged in misconduct regardless of whether they reported the misconduct. No Affected Individual will incur negative repercussions solely for mistakenly reporting what they believed to be an act of misconduct, but an individual may be subject to disciplinary action if the report was knowingly misstated.

Compliance inquiries may be included in exit interviews conducted by Human Resources. Departing employees may be asked if they had knowledge of or suspected potential misconduct or violations of laws, standards or policies and procedures. Human Resources will encourage departing employees who identify compliance concerns to contact the Compliance Officer and will forward concerns to the Compliance Officer for follow-up. Compliance concerns identified via exit interviews will be processed in the same manner as other compliance concerns.

All compliance reports received will be investigated and reported by the Compliance Officer or designee in accordance with Section VII below.

V. ENFORCEMENT AND DISCIPLINARY GUIDELINES

The goal of this Plan is to encourage good faith participation by all Affected Individuals in the Compliance Program by reporting and assisting in the resolution of compliance issues. Violations of this Plan may result in disciplinary actions being taken up to and including termination of employment or affiliation with AH. Such violations include, but not limited to, the following:

- 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 employees relating to compliance or applicable laws or regulations; and
- Failure of supervisory or management personnel to detect non-compliance with applicable policies and legal requirements and this Program, where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems.

Any Affected Individual who intentionally fails to comply with applicable laws, regulations, standards and policies may be subject to disciplinary action, up to and including termination of employment/affiliation.

Corporate compliance policies and procedures will be applied and enforced consistently, fairly and firmly. The disciplinary action taken will follow AH's existing disciplinary policies. The Department Director, Compliance Officer and Chief Human Resources Officer will collaborate as necessary in compliance related disciplinary investigations and disciplinary actions. AH reserves the right to exercise discretion in determining the disciplinary penalty for violating a compliance standard, with intentional or reckless behavior being subject to the most significant sanctions.

The disciplinary system is to be in compliance with Human Resources and/or Medical Staff protocols and shall provide that disciplinary actions, including a statement of the reasons why the disciplinary penalty was imposed, are documented in the personnel and/or peer review file. The Human Resource Office will maintain a record of all disciplinary actions taken regarding compliance violations by employed Affected Individuals. The Medical Staff Office will do the same for credentialed Staff, and the Board of Trustees will maintain records of any such disciplinary actions being taken against its members. The Compliance Officer will maintain all other records related to these actions, including disciplinary actions taken against contractors. The Compliance Officer will report to the Corporate Compliance Committee on a regular basis concerning the disciplinary actions taken.

VI. AUDITING, MONITORING AND REMEDIATION SYSTEMS

AH's monitoring and audit process will assess compliance with laws, regulations, standards, policies and procedures, and the effectiveness of AH's Compliance Program. The scope and frequency of compliance monitoring and auditing activities in a particular area will be based on an assessment of risk and the effectiveness of existing operational controls and on-going monitoring activities.

The Compliance Officer and Corporate Compliance Committee will establish guidelines to assure monitoring and audit coverage for all high-risk areas. All monitoring and audit activities requested by the Corporate Compliance Committee will be reported to the Committee at the meeting following the completion of the review or at least annually for those routine compliance monitoring and audit activities. More frequent reporting will be at the discretion of the Compliance Officer or Corporate Compliance Committee.

Monitoring may include the use of internal resources and outside expertise. Audits and monitoring procedures may be conducted with guidance from legal counsel under attorney/client privilege.

Routine monitors may be selected based on the recommendation of the Compliance Officer, Department Directors or the Corporate Compliance Committee. Examples of potential routine monitors may include:

- Review of the organization's business and financial relationships with contractors and physicians
- Periodic random sample of cases reviewed to determine if problems exist, such as excessive ordering of tests or imaging for financial gain.
- Trend analysis to determine if there are any concerns with changes in case mix or coding practices.
- Claims denials or diagnosis code and DRG changes from Fiscal Intermediary (FI) or federal Quality Improvement Organizations (QIO's).
- Charge to chart audits to assure charges are supported by documentation in the chart.
- Risk areas identified in internal or external audits, or audits conducted by the State or Federal government.

Auditing and monitoring will occur in the following areas:

- Billings
- Payments
- Medical necessity and quality of care
- Governance
- Mandatory reporting
- Credentialing
- Other risk areas identified by the Compliance Officer

Follow-up or re-audits and monitoring will be used to assure that identified issues remain corrected and as a way to assure corrective actions have been effective at preventing recurrence. If an audit, study or monitor has identified a significant problem that has since been addressed, a re-audit is to be completed within a reasonable amount of time. Parameters for re-audits will be established by the Corporate Compliance Committee in consultation with the Compliance Officer, along with a time period in which the findings are to be presented to the Committee.

Clear and timely documentation will be maintained indicating the reasons for conducting an audit or assessment, how the audit or assessment was conducted, and the results and follow-up actions taken. Records of these activities will be kept confidential and maintained by the Department Director overseeing the area or issue monitored, in a secure location, for seven (7) years. The results of any compliance audits or monitoring activities will be promptly shared with the Compliance Officer if not conducted by the Compliance Officer. The Compliance Officer will share the results of any internal or external audits with the Corporate Compliance Committee and the Board of Trustees.

Any Medicare or Medicaid overpayments identified will be reported, returned and explained in accordance with applicable laws and regulations.

Annual Compliance Program Review

At least annually, the Compliance Officer and the Corporate Compliance Committee will review the Compliance Program to determine its effectiveness and whether any revision or corrective action is required. Such reviews may include assistance from external auditors and other staff who have the necessary knowledge and expertise to evaluate the effectiveness of the components of the Compliance Program they are reviewing and are independent from the functions being reviewed.

The reviews will include on-site visits, interviews with Affected Individuals, review of records, surveys, or any other comparable method AH deems appropriate, provided that such method does not compromise the independence or integrity of the review. The Compliance Officer will document the design, implementation and results of the effectiveness review, and any corrective action implemented. The Compliance Officer will share the results of the annual Compliance Program review with the President/CEO, senior management, Corporate Compliance Committee, and the Board of Trustees (through the Audit and Compliance Committee).

Screening of Affected Individuals

Affected Individuals will be screened upon hire or affiliation and thereafter monthly to confirm identity and determine whether they have been disbarred or excluded by a Federal or State agency. It is AH's policy not to hire or retain any person or any entity that has been disbarred or excluded from the Medicare or Medicaid programs, including but not limited to any person or entity that has been so convicted, excluded, or debarred.

If AH becomes aware of the foregoing, AH will promptly ensure that no claims are submitted for services ordered or furnished by any person or entity, including physicians that AH knows is excluded from participation in the Medicare or Medicaid programs. AH will also determine whether any of its contractual arrangements with the individual or entity should be terminated.

Department Directors will assure that all new proposed contracted individuals (excluding Medical and Associate Staff, whose exclusion checks are completed by the Medical Staff Coordinator), vendors, and other entities are subject to an initial exclusion screening prior to onboarding. This screening will be completed and/or confirmed by Human Resources (HR) staff for employees and contract staff, by the Compliance Officer for vendors, and by the Medical Staff Coordinator for the Medical Staff. Thereafter, such screenings will occur every thirty (30) days. Exclusion checks will be conducted by reviewing the exclusion lists from the Office of Inspector General (OIG), Office of the Medicaid Inspector General (OMIG), and the System for Award Management (SAM).

Reference: Policy CC020 Identification of Individuals and Entities Excluded from Participation in Federal and/or State Health Care Programs.

VII. INVESTIGATION AND CORRECTIVE ACTION PLANS

AH will promptly respond to any compliance issues raised, investigate potential compliance problems as identified in the course of its internal auditing and monitoring activities, correct such problems promptly and thoroughly to reduce the potential for reoccurrence, and ensure ongoing compliance with State and Federal laws, rules and regulations, and requirements of the Medicaid program.

Upon receipt of a potential compliance issue, including any issues identified in the course of audits or self-evaluations, the Compliance Officer will take all reasonable steps to promptly investigate the situation for purposes of assessing legal risks or obligations.

The Compliance Officer will enter the concern in the corporate compliance log and if there is a potential compliance issue, open a written report. Issues that are not compliance related will be referred to the appropriate committee or administrative member for follow-up; they will not be addressed through Corporate Compliance.

Based upon the information given and the nature of the concern, the Compliance Officer will conduct an initial assessment to determine whether the report has merit and warrants additional investigation. The Compliance Officer either alone or in consultation with the individual's supervisor and/or legal counsel will make a determination as to who should conduct the investigation -- the supervisor, Compliance Officer, legal counsel or an outside expert retained by legal counsel. Investigations will start as soon as possible but in no event more than fourteen (14) business days following the receipt of the report suggesting a potential compliance issue.

Investigation activities may include, but not be limited to, the following:

- Review of applicable laws, regulations and standards;
- Interviews with the person reporting the concern and others who may be involved or have information to support the investigation;
- Review of relevant documents including both financial and clinical records;
- Obtaining the facts, their significance, and evidence;
- Identifying the corporate compliance policy, procedure, protocol, or law that is applicable to the issue to determine the violation;
- Following policy or protocol developed for investigations or as recommended by an AH attorney or other outside authority assisting AH in the investigation;
- Assistance in determining disciplinary and corrective actions.

If the Compliance Officer believes that the integrity of the investigation is at stake due to the presence of the employee under investigation, the employee may be relieved of their position at the discretion of the Compliance Officer in consultation with the President/CEO or designee and the Chief Human Resources Officer. The Compliance Officer shall take necessary steps to prevent the destruction of documents, electronic records or other evidentiary material relevant to an investigation.

If, upon conclusion of the investigation and review by the Compliance Officer, Senior Management and/or legal counsel, it is determined that there is a substantiated compliance concern, the Compliance Officer shall immediately formulate and implement a corrective plan of action. The corrective plan of action will ensure that the issue is promptly and thoroughly corrected, eliminated and/or mitigated to reduce the chance that the situation recurs and to ensure ongoing compliance with any applicable laws and regulations, including the medical assistance programs requirements (Medicaid). Corrective action may include, but is not limited to, adopting new policies and procedures and monitoring their implementation, imposing restrictions on the duties of Affected Individuals, education and training, discipline of Affected Individuals including suspension up to and including termination, and disclosure to governmental authorities as required by law.

For individuals who have participated in activities that are illegal, unethical, and/or non-compliant with this Plan, corrective action will be initiated immediately by their supervisor or Department Director. Protocols for corrective actions will be based on Human Resources protocols, policies and procedures and recommendations. If indicated, the Corporate Compliance Officer, Corporate Compliance Committee, Board of Trustees, Senior Management and/or legal counsel will assist in directing the corrective action. In addition, required reporting to intermediaries, governmental agencies and other authorities and organizations will be completed as required based on the offense. Follow-up monitoring will be established to assure resolution of the concern.

If the compliance problem relates to billing, similar billing will be discontinued until the problem is corrected and education on appropriate billing processes is provided. If improper payments were received, whether through a billing problem or otherwise, the Director of Patient Financial Services with support from the Compliance Officer, Senior Management and/or legal counsel will determine the amount of repayment to be made and the required disclosures. Any Medicare or Medicaid overpayments will be reported and returned in accordance with applicable law.

If there is reason to believe that the misconduct may have violated criminal, civil or administrative law, or applicable regulations, the misconduct will be reported to the appropriate authority (including, but not limited to, the Centers of Medicare and Medicaid, NYS Department of Health and/or the NYS Office of Medicaid Inspector General) as legally required.

Documentation of the investigation will be maintained by the Compliance Officer and will include the alleged violations, description of the investigation process, copies of interview notes, other documents essential for demonstrating that AH completed a thorough investigation, and disciplinary action and corrective action implemented. Each of these investigations will be listed on the Corporate Compliance log with a summary of the issue and investigation included in the Corporate Compliance Reports to the Board of Trustees.

When appropriate, the Compliance Officer will discuss the outcome of the compliance investigation with the individual reporting the concern. The Compliance Officer will maintain records of investigations including documentation of the alleged violation, a description of the investigative process, interview notes and copies of key documents, interviewed witness and documents reviewed log, the results of the investigation and the corrective action. These records will be kept for seven years.

Issues requiring corrective actions will be evaluated by the Corporate Compliance Committee for consideration as potential priorities for monitoring and/or incorporation into audits. The committee will make recommendations for the most appropriate follow-up to assure continued resolution of problems.

VIII ADMINISTRATIVE ACTIVITIES IN SUPPORT OF CORPORATE COMPLIANCE

Corporate Compliance Records

A permanent record of any reports of real or potential noncompliance issues will be maintained in accordance with Adirondack Health Policy CC030 "Record Retention and Destruction". Records regarding corporate compliance, if not otherwise directed in this plan, will be kept in the Corporate Compliance Officer's office. Confidential records will be kept in a locked file.

This includes a copy of reports to the Board of Trustees and Corporate Compliance Committee Minutes.
Records will be available upon request for any state or federal official requesting review.

Employee Handbook

The AH employee handbook will reference the requirements of the Compliance Program and explain AH's whistleblower/non-retaliation and non-intimidation policy in accordance with application Federal and State laws and regulations.

Human Resource Activities Related to Compliance

Human Resources policies, procedures and protocols that address corporate compliance will be consistent with this Plan and all compliance-related polices.

Payment Monitoring

Policies and protocols will be maintained by the Finance Department to assure appropriate utilization of funds. Routine monitors will be established to assure the accuracy and appropriateness of incoming payments and outgoing obligations, including the annual audit by a recognized external auditing firm approved by the Board of Trustees.

Payment errors will be appropriately documented and forwarded to the attention of the Chief Financial Officer. If any are identified as corporate compliance issues, they will be reported to the Compliance Officer and Corporate Compliance Committee by the Chief Financial Officer. Results of routine monitors and audits will be shared with the Corporate Compliance Committee on a quarterly basis and reported to the Audit and Compliance Committee of the Board by the Compliance Officer.

Any Medicare or Medicaid overpayments identified will be reported, returned, and self-disclosed as required by and in accordance with applicable Federal and State laws and regulations. The Director of Patient Financial Services will maintain a policy and/or protocol that establishes the proper steps to follow to assure overpayment received by AH is returned.

AH Policies, Procedures and Protocols Relating to Compliance

Adirondack Health maintains numerous policies throughout its organization that further delineate procedures, protocols and expectations of Affected Individuals and associates. The Compliance Plan includes oversight where ethical behavior and compliance protocols are listed to prevent as well as eliminate fraud waste and abuse. Affected Individuals are to adhere to these guidelines in compliance with this Plan.

Availability of Corporate Compliance Plan

A copy of this Corporate Compliance Plan is available to all Affected Individuals at the following locations:

AH web site: www.adirondackhealth.org
AH's Intranet: http://ahweb:85/
AH at Saranac Lake Site: Administration, Corporate Compliance Office
AH Mercy Living Center: Administrative Offices

Attestation of Intent to Comply with the AH Corporate Compliance Plan

All Affected Individuals will be required to attest to their agreement to comply with this Plan. Human Resources will obtain an attestation from all employees and volunteers at the time of employment/commencement or service or shortly thereafter. Evidence of this will be maintained by Human Resources.

The members of the Board of Trustees will provide evidence of their acknowledgement certifying their understanding and intent to comply with the Corporate Compliance Program when accepting a position on the Board of Trustees. Evidence of this will be maintained by Senior Management.

The Medical Staff will provide evidence of their acknowledgement certifying their understanding and intent to comply with the Corporate Compliance Program when accepting a position at AH. Evidence of this is maintained by the Medical Staff Office.

The Compliance Officer will develop and implement a process for obtaining similar attestations from vendors and independent contractors.

Attestations will include the Affected Individual's acknowledgement and agreement that:

1. They have read and understand the Corporate Compliance Plan and the Code of Conduct.
2. They pledge to act in accordance with the Corporate Compliance Plan and the Code of Conduct.
3. They will promptly report any conduct that they believe to be illegal or in violation of the Corporate Compliance Plan or the Code of Conduct in accordance with the compliance concern reporting steps.
4. They will not retaliate or intimidate any Affected Individual who participates in the Compliance Program.
5. They will seek advice from their supervisor or the Compliance Officer concerning appropriate actions that they may need to take in order to comply with the Corporate Compliance Plan or the Code of Conduct.
6. They understand that failure to comply with this Code of Conduct may result in disciplinary action, up to and including termination of employment, affiliation or contract.

Summary of Federal and State Laws Regarding False and Fraudulent Claims and Whistleblower Protections

In summary, the federal False Claims Act ("FCA") and New York State False Claims Act ("SFCA") impose penalties and damages on anyone who knowingly makes or causes to make a false claim for payment or a false statement or record to facilitate a false claim, or knowingly fails to deliver money belonging to the federal, state or local government.[1] The FCA makes persons who commit certain fraudulent acts liable to the federal government; and the SFCA makes persons who commit certain fraudulent acts liable to New York State and any local government within New York State.[2]

In addition, federal and state law protects those who commence actions or pursue other measures to prevent fraudulent acts, also known as whistleblowers. Specifically, an employee or other individual who commences a FCA action is protected against threats, harassment, demotion, and suspension, as well as any other form of discrimination that arises as a result of such individual's commencement of an action or the implementation of other measures to stop violations of the FCA.[3] In general, relief includes: (i) reinstatement; and (ii) "2 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 attorneys' fees."[4] The SFCA under State Finance Law Article XIII provides similar protections and relief to individuals who commence an action or pursue other measures to stop violations of Article XIII.[5]

Additional whistleblower protections are afforded under New York State Labor Law § 740, which allows employees retaliated against to bring a civil action against the employer for, among other things, injunctive relief; reinstatement; and compensation for lost wages, reasonable costs, and attorneys' fees.[6] Additionally, a healthcare provider found to be acting in bad faith by a court of competent jurisdiction may be fined up to $10,000.[7] New York State Labor Law § 741, which specifically applies to healthcare providers, provides similar retaliatory protections to employees.[8]

Provided below are key federal and state anti-fraud and abuse laws regarding the submission of false and fraudulent claims to the federal and state governments, and related whistleblower protections.

Compliance with the Deficit Reduction Act of 2005, Federal and State False Claims Acts, and Federal and State Laws Related to the Commission of Health Care Fraud, and Whistleblower Protections Summary

I. FEDERAL LAWS

A. Deficit Reduction Act of 2005 Obligation (42 USC § 1396a(a)(68))

A State plan for medical assistance must—

(68) Provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall-

[1] *See* 31 U.S.C. § 3729(a)(1)(A-G); *see also* State Finance Law § 189(1).
[2] *See, generally*, 31 U.S.C. §§ 3729 et seq.; State Finance Law Article XIII.
[3] *See* 31 U.S.C. § 3730(h)(1).
[4] *Id*. at § 3730(h)(2).
[5] *See* State Finance Law § 191(1); *see, also, generally* State Finance Law Article XIII.
[6] *See* New York Labor Law §§ 740(4)(a), 5(a – b), and 5(d – e).
[7] *See id*. at § 740(4)(d).
[8] *See id*. at § 741(2).

(A) Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) of this title);

(B) Include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) Include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

B. Federal False Claims Act (31 USC §§ 3729-3733)

The Federal False Claims Act ("FCA") provides, in pertinent part, as follows:

§ 3729. False claims

(a) Liability for certain acts.—

(1) In general.-Subject to paragraph (2), any person who-

(A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) Conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) Has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases 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, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 USC 2461 note; Public Law 104–410), plus 3 times the amount of damages which the Government sustains because of the act of that person.[9]

(2) Reduced damages.-If the court finds that-

(A) The person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) Such person fully cooperated with any Government investigation of such violation; and

[9] *See* reference to increased penalty amounts in Section C below.

(C) At the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.-A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions.--For purposes of this section—

(1) The terms "knowing" and "knowingly" -
(A) Mean that a person, with respect to information-
(i) has actual knowledge of the information;
(ii) acts in deliberate ignorance of the truth or falsity of the information; or
(iii) acts in reckless disregard of the truth or falsity of the information; and
(B) require no proof of specific intent to defraud;

(2) The term "claim" -
(A) Means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that-
(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government-
(I) provides or has provided any portion of the money or property requested or demanded; or
(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
(B) Does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) The term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) Exemption from disclosure.--Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

In sum, the FCA imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds, that he or she knows (or should know) is false. The FCA also imposes liability on an individual who knowingly submits a false record in order to obtain payment from the government, or who receives and retains money from the federal government to which he/she is not entitled.

While the FCA 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, also can be found liable under the Act.[10]

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States.[11] These private parties, known as "qui tam relators," may share in a percentage of the proceeds from a 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 15 percent but not more than 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 25 percent and not more than 30 percent of the proceeds of the FCA action.

C. Administrative Remedies for False Claims and Statements (31 USC §§ 3801 – 3812)

This statute allows for administrative recoveries by federal agencies where the Department of Justice elects not to pursue FCA remedies. If a person submits a claim or written statement that the person knows is false, fictitious, or fraudulent, includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent, or omits material information, the agency receiving the claim or written statement may impose a penalty of up to $12,536 for each claim. The amount of the penalty imposed under this statute may be periodically adjusted by Congress for inflation. In addition, the agency may recover an assessment, in lieu of damages, of up to twice the amount of the claim.[12]

D. Health Insurance Portability and Accountability Act (42 CFR § 160.316)

Under the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, an employee or patient is protected from threats, intimidation, coercion, harassment, discrimination or other retaliatory action for (a) filing a complaint of a violation of HIPAA, (b) testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing regarding a HIPAA violation; or (c) opposing any act or practice made unlawful by HIPAA, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of protected health information in violation of HIPAA's privacy rules.

II. NEW YORK STATE LAWS

New York State laws governing false and fraudulent claims fall under the jurisdiction of both New York's civil and administrative laws, as well as its criminal laws. Some apply to beneficiary false claims and some apply to provider false claims. The majority of these statutes are specific to health care or Medicaid fraud.

A. CIVIL AND ADMINISTRATIVE LAWS

1. New York False Claims Act (State Finance Law §§ 187-194)

The New York State False Claims Act is similar to the federal FCA, and imposes penalties and fines upon individuals and entities who knowingly present false or fraudulent claims for payment to any state or local government, including healthcare programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal

[10] *See* 31 USC § 3729(b).
[11] *See* 31 USC § 3730(b).
[12] For penalties assessed by the Department of Justice after January 30, 2023 for violations that occurred after November 2, 2015, the FCA civil penalty increased to a minimum of $13,508 up to a maximum of $27,018 per claim. In addition, the civil penalty for violations of the Administrative Remedies statute increased to $12,536 per claim. *See* 87 FR 2065 (Jan. 30, 2020).

FCA such that a person or entity will be liable in instances where the person obtains and retains money from a state or local government to which he or she may not be entitled.

The penalty for filing a false claim under the New York False Claims Act is $6,000 to $12,000per claim plus three times the amount of all damages, including consequential damages, which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs and attorneys' fees of a civil action brought to recover any such penalty.

The New York False Claims Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to possible limitations imposed by the New York State Attorney General or a local government. If the suit is successful, the person who started the case can recover 25 to 30% of the proceeds if the government did not participate in the suit, or 15 to 25% if the government did participate in the suit.

2. Social Services Law, Section 145-b - False Statements

Under § 145-b of the New York Social Services Law, it is illegal to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment, or other fraudulent scheme or device.

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

3. Social Services Law, Section 145-c - Sanctions

Under § 145-c of the New York Social Services Law, if any individual applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, neither the needs of the individual nor of his/her family shall be taken into account for the purpose of determining his/her needs or that of his/her family. This penalty shall be in effect for six months for a first offense, for twelve months in the event of a second offense (or if benefits wrongfully received are at least $1,000 but not more than $3,900), for eighteen months for a third offense (or if benefits wrongfully received are in excess of $3,900), or five years for any subsequent occasion of any such offense.

B. CRIMINAL LAWS

1. Social Services Law, Section 145 - Penalties

Pursuant to § 145 of the New York Social Services Law, any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2. Social Services Law, Section 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 a 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.

3. 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. This statute 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.

4. 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 in the second degree involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

b. § 175.10 - Falsifying business records in the first degree includes the elements of the § 175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

c. § 175.30 - Offering a false instrument for filing in the second degree involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. It is a Class A misdemeanor.

d. § 175.35 - Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

5. Penal Law Article 176 - Insurance Fraud

This statute 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 and having been previously convicted within the five years preceding any offense. It is a Class D felony.

6. Penal Law Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to healthcare fraud crimes. It was designed to address the specific conduct by healthcare providers who defraud the healthcare system, including any publicly or privately funded health insurance or managed care plan or contract, under which any healthcare item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid, and contains five crimes.

a. Health care fraud in the fifth degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a Class A misdemeanor.

b. Health care fraud in the fourth degree – a person is guilty of this crime upon filing false claims on more than one occasion and annually receiving over $3,000 in the aggregate . This is a Class E felony.

c. Health care fraud in the third degree – a person is guilty of this crime upon filing false claims on more than one occasion and annually receiving over $10,000 in the aggregate. This is a Class D felony.

d. Health care fraud in the second degree - a person is guilty of this crime upon filing false claims on more than one occasion and annually receiving over $50,000 in the aggregate. This is a Class C felony.

e. Health care fraud in the first degree - a person is guilty of this crime upon filing false claims on more than one occasion and annually receiving over $1 million in the aggregate. This is a Class B felony.

III. FEDERAL AND STATE WHISTLEBLOWER PROTECTIONS

A. Federal False Claims Act (31 USC § 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.[13]

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.

B. New York False Claims Act (State Finance Law § 191)

The New York False Claims 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 False Claims 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.

[13] *See* 31 USC § 3730(h).

C. New York Labor Law § 740

An employer may not take any retaliatory action against an employee if the employee discloses to a regulatory, law enforcement, or other similar agency or public official an activity, policy, or practice of the employer that is in violation of law, rule, or regulation that creates and present a substantial and specific danger to the public health or safety, or which constitutes health care fraud. An employee is also protected from retaliatory action if the employee objects to, or refuses to participate in any such activity, policy, or practice in violation of a law, rule, or regulation. The employee is protected from retaliatory action only if the employee first raised 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 healthcare provider, and the court finds that the employer's retaliatory action was in bad faith, the court may impose a civil penalty of up to $10,000 on the employer.

D. New York Labor Law § 741

A healthcare employer may not take any retaliatory action against an employee if the employee discloses to a regulatory, law enforcement, or other similar agency or public official the employer's policies, practices, or activities that the employee believes in good faith constitute improper quality of patient care. An employee is also protected from retaliatory action by an employer for objecting to, or refusing to participate in any activity, policy, or practice of the employer that the employee, in good faith, reasonably believes constitutes improper quality of patient care. The employee is protected from retaliatory action only if the employee first raised 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 healthcare provider and the court finds that the employer's retaliatory action was in bad faith, the court may impose a civil penalty of up to $10,000 on the employer.