Genesee County

Corporate Compliance Plan

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I. Policy Statement

Preventing and detecting health care fraud and abuse activities is an important fiduciary responsibility of the County Legislature, management and all staff.

As such, Genesee County has adopted a Compliance Program, effective November 1, 2007, to help ensure that the organization maintains a high level of honesty and ethical behavior in all aspects of its delivery of services and relations with residents, third party payers, employees, agents, and independent contractors.

The intent is to reasonably design, implement and enforce a Compliance Program that will disclose, prevent, and detect misconduct. All individuals employed by Covered Departments (Public Health and Mental Health), all contractors (including contractors, independent contractors, agents, and subcontractors) providing services and supplies to Covered Departments, individuals on the Public Health and Mental Health Boards, and the County Legislature and Compliance Committee members (Affected Individuals) are expected to understand and adhere to this Compliance Program. Conduct contrary to this expectation will be considered a violation of the Compliance Program and will be subject to disciplinary action.

II. Code of Conduct

It is the policy of Genesee County that all employees comply with laws, regulations, policies, and ethical standards applicable to their duties and outlined in this Code of Conduct. The following standards of conduct have been adopted by the Genesee County Legislature and apply to all.

General Standards

Confidentiality: Affected Individuals must respect the confidential nature of resident and organization information, and shall refrain from disclosing or discussing issues of a confidential nature inappropriately. Information obtained through employment or association with Genesee County must not be used to benefit other employees or organizations.

Honesty and Lawful Conduct: Affected Individuals must be honest and truthful in all of their dealings. They must avoid doing anything that is, or might be, against the law. If you are unsure whether an action is lawful, you should check with your Supervisor or the County Compliance Officer.

Misrepresentation: Honesty based on clear communication is the cornerstone of ethical disclosure of information. Affected Individuals shall be honest and make no representation or dishonest statements in conducting County business affairs. Affected Individuals must report and record all information accurately and honestly, including all marketing materials, service records, requests for payment, timesheets, financial reports, and other similar documents, which relate to business activities.

Non-Discrimination: All Affected Individuals associated with the County shall adhere to state and federal laws prohibiting discrimination because of age, race, sex (including pregnancy, sexual orientation, gender identity and gender expression), color, marital status, disability, religion or national origin while conducting business activity of the County.

Organizational Assets: All assets of the County shall be used solely for the benefit and purpose of the organization. Personal use of the County's assets is not allowed, unless disclosed to, and approved by the Compliance Committee.

Respect for Patients/Clients Served: Affected Individuals must fully respect the rights of the patients/clients served including their right to privacy, respect, self-determination, participation in their own care and treatment, freedom of choice, ability to voice grievances, and reasonable accommodation of needs.

Safe Workplace: The County has a commitment to maintain a safe and healthful workplace for County employees and people receiving services. As part of this commitment, the County maintains reasonable safety rules, practices and procedures for all County employees. At the same time, the County expects all representatives to be efficient and productive in performing their job assignments.

Billing for Services

Accurate and Truthful Claims: Claims submitted for payment must be accurate and truthful, and reflect only those services and supplies which were ordered and provided. Non-allowable costs must be appropriately identified and removed, and related party transactions must be treated consistent with applicable laws and regulations.

Adequate Documentation: Billing of services and supplies must be based on accurate and adequate documentation to support the services and supplies, and in accordance with applicable laws and regulations and third party payer requirements.

Coding: Coding of services shall accurately reflect the services rendered. Employees and/or contractors who perform coding and billing shall receive training on current regulations and codes annually or more frequently as needed. Such training is intended to incorporate compliance concepts and updates of regulatory information.

Excluded Providers: Claims for items or services furnished by an individual or entity that has been excluded from participation in a federal or state health care program shall not knowingly be submitted for payment.

Inadequate or Substandard Care or Services: Claims shall not be knowingly submitted for payment for inadequate or substandard care or services.

Record Retention: Records that demonstrate the right to receive payment, including medical records, will be retained for ten (10) years.

Payment

Credit Balances: A credit balance is an excess or improper payment as a result of billing or claims processing errors. If a department or program knows that it has received payments for which it was not entitled from a governmental or private payer or a recipient, the payments will be refunded to the appropriate payer or recipient.

Exception for Nominal Value: Affected Individuals may provide or receive ordinary and reasonable business entertainment and gifts of nominal value, if those gifts are not given for the purpose of influencing the business behavior or clinical evaluation of the recipient. Nominal value is defined by the U.S. Department of Health and Human Services Office of Inspector General as no more than $15 per gift or $75 per person per year.

Payment of Items or Gifts: Affected Individuals may not give anything of value, including bribes, kickbacks, or payoffs to any government representative, fiscal intermediary, carrier, contractor, vendor, or any other person in a position to benefit the County in any way

Receipt of Bribes, Gifts and Gratuities: Affected Individuals may not accept bribes, gifts or gratuities intended to persuade business decisions, solicit an unfair advantage, or reward special attention or service. There will be no loans to or from any individual or business (other than recognized financial institutions) that furnish or receive supplies or services to Genesee County.

Medical Necessity and Quality of Care and Services

Ability to Provide: Genesee County will refer patients/clients and their families to other appropriate providers when it cannot provide for the patient/client's identified needs.

Accountability: Affected Individuals shall be responsible for being knowledgeable, balancing patient/client needs, allowable benefits, and limited resources in carrying out services, supervision, and care management.

Appropriate Treatment: Genesee County shall provide appropriate and sufficient treatment and services to address patients/clients clinical conditions in accordance with their plans of care and professional standards of practice.

Delivery of Care and Services: Patients/clients served by Genesee County will be afforded the care and services necessary to attain or maintain the highest possible physical, mental, and psycho-social well-being. All employees will be trained to evaluate and provide appropriate services and are encouraged to ask management if unsure in any area.

Medical Necessity: Medical care and services shall be based on medical necessity and professionally recognized standards of care. Non-medical services shall be based on the programmatic requirements for those services.

Governance

Conflict of Interest: Any actual or potential conflict of interest must be disclosed to ensure that the integrity of Genesee County's operations are not compromised. Affected Individuals must disclose to the Compliance Officer any financial interest that they or a member of their family have in any entity that does business or competes with the organization in any manner.

Mandatory Reporting

Abuse, Neglect, Mistreatment: Patients/clients receiving services will be free from abuse, neglect and mistreatment. Any allegations of abuse, neglect or mistreatment must be immediately reported to the appropriate supervisor and other officials as required by law and investigated in accordance with applicable policies, rules, and regulations.

Credentialing

Personnel Credentialing: The County shall conduct exclusion searches in an effort to determine the exclusion status of all Affected Individuals. These searches will be completed using the County's subscription to K-checks Automated Exclusion Management System. It will automatically search a central repository on a monthly basis (every thirty (30) days) for individuals and entities that have been excluded from participating in federally funded healthcare programs including Medicaid and Medicare.

Business Practices

Financial Reports: Expense reports, reimbursement requests, financial statements, and cost reports shall be completed thoroughly and accurately. No Affected Individual shall willfully or purposely misrepresent any financial reports or reimbursements.

Financing/Loan Agreements: The County and all Affected Individuals, as appropriate, shall maintain a familiarity with the terms, conditions and covenants contained in any financing/loan agreements and shall refrain from engaging in any activity in direct conflict or breach of these terms, conditions or covenants.

Improper and Illegal Means: The County will forego any business transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to anyone to induce the use of the County's services.

Medicare/Medicaid Anti-Kickback: No Affected Individual associated with the County shall engage in any unlawful acts of accepting payments or benefits in return for generating Medicare/Medicaid business activity.

Purchasing: Purchasing decisions must be made with the purpose of obtaining the highest quality product or service for the County at the most reasonable price. No purchasing decision may be made based on considerations that Affected Individuals or their family member or friend, will benefit.

Scope and Application of Standards to Affected Individuals

Responsibility of all Affected Individuals: Affected Individuals are expected to be familiar with and comply with all federal and state laws, regulations, rules, policies, and standards that govern their job or role at, or relationship with, the County. Affected Individuals are also required to comply with this Compliance Plan (including the Code of Conduct) and Compliance Program and any applicable departmental and other compliance policies and procedures. In addition to this Compliance Plan, affected departments have compliance policies and procedures. These policies and procedures are an integral part of the Compliance Program and are designed to complement the standards set forth in the Compliance Plan.

Strict compliance with such standards is a condition of employment or relationship with the County, and violation of any of these standards will result in discipline, up to and including termination.

III. Oversight Responsibility

Compliance Officer

Genesee County has designated an individual to serve as the County's Compliance Officer. The Compliance Officer is responsible for overseeing the day-to-day operation of the Genesee County Compliance Program, and is the focal point of the County's Compliance Program. The duties and responsibilities of the Compliance Officer shall be as follows:

- Develop and implement compliance policies and procedures.
- Facilitate, write, implement and update the compliance work plan at least annually, or as otherwise necessary, to conform to changes to federal and state laws, rules, regulations, policies, and standards. The compliance work plan shall outline the County's proposed strategy for meeting the Compliance Regulations' requirements for the coming year, and shall place a specific emphasis on written policies and procedures, training and education, auditing and monitoring, and responding to compliance issues.
- Oversee and monitor the Compliance Program's adoption, implementation, and maintenance, and evaluate the Compliance Program's effectiveness.
- Oversee and ensure that the County takes reasonable steps to achieve compliance with its standards by utilizing monitoring and auditing systems reasonably designed to detect misconduct by the County's Affected Individuals.
- Delegate appropriate levels of monitoring and review of systems to other Affected Individuals, including employees and outside agencies, to promote effectiveness, efficiency, and to avoid any potential conflicts of interest.
- Provide guidance to management and personnel regarding compliance policies and procedures.
- Periodically review and update the Compliance Plan and Compliance Program, including the County's written policies and procedures and Code of Conduct, as changes occur.
- Promptly review and revise the Compliance Plan, Compliance Program, written policies and procedures, and Code of Conduct to incorporate changes to federal and state laws, rules, regulations, policies and standards.
- Oversee and ensure that the County takes steps to effectively communicate its Compliance Program policies, procedures, and Code of Conduct to all Affected Individuals, including Medicaid recipients and agents.
- Coordinate, develop, and participate in periodic compliance trainings.
- Actively seek up-to-date material and releases regarding compliance.
- Maintain a reporting system and respond to concerns, complaints, and questions related to the Compliance Plan.

- Investigate and independently act on matters related to the County's Compliance Program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal County departments, contractors, and New York State.
- Report any and all compliance and work plan activity, including the progress of adopting, implementing, and maintaining the County's Compliance Program, to the Compliance Committee and County Legislature quarterly, or more frequently as needed.
- Follow-through on any detected or reported incidents of possible misconduct under the direction and supervision of legal counsel when necessary.
- Oversee the completion and filing of Compliance Certifications to the applicable government regulatory agencies.
- Assist the County in establishing methods to improve the County's efficiency, quality of services, and reducing the County's vulnerability to fraud, waste, and abuse.

The Compliance Officer shall report directly and be accountable to the County's Chief Executive. In addition to the duties and responsibilities outlined above, the Compliance Officer may also be assigned additional other duties. In assigning other additional duties, the County will ensure that the duties do not hinder the Compliance Officer's ability to carry out their primary compliance-related responsibilities.

The County will ensure that the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the Compliance Program based on the County's Compliance Risk Areas and Organizational Experience. Moreover, the County shall ensure that the Compliance Officer and appropriate compliance personnel have access to all records, documents, information, facilities, and Affected Individuals that are relevant to carrying out their Compliance Program responsibilities.

Compliance Committee

The County has designated a Compliance Committee which is responsible for coordinating with the Compliance Officer to ensure that the County is conducting its business in an ethical and responsible manner, consistent with its Compliance Program. The role of the Compliance Committee is to provide oversight for regulatory and legal compliance issues and ensure Genesee County meets or exceeds the highest standards of regulatory and legal accountability as well as ethical activity by County employees. In addition, the Compliance Committee's role is to advise the Compliance Officer and assist in the implementation of the Compliance Plan. The scope of the Committee's authority (and the Committee's responsibilities) includes:

- Identification of specific Compliance Risk Areas,
- Assessing existing policies and procedures that address those Compliance Risk Areas and modifying them as needed,
- Working with departments and the Compliance Officer to develop or modify the Code of Conduct, policies and procedures to promote compliance with legal and ethical requirements,

- Coordinating with the Compliance Officer to ensure that the County's written policies, procedures, and Code of Conduct are current, accurate, and complete,
- Coordinating with the Compliance Officer to ensure that the training topics required by the Compliance Regulations are timely completed,
- Developing and evaluating appropriate strategies to promote compliance with the Compliance Program and detection of any potential violations,
- Coordinating with the Compliance Officer to ensure communication and cooperation by Affected Individuals on compliance related issues, internal or external audits, or any other function or activity required by the Compliance Regulations;
- Evaluating and approving all Compliance Program initiatives, processes and documentation,
- Receiving, reviewing, and recommending appropriate responses to reports of actual or potential non-compliance with applicable laws, rules, regulations, policies, and standards, and the County's Code of Conduct, policies, and procedures in coordination with the Compliance Officer and with the assistance of counsel as necessary,
- Advocating for the allocation of sufficient funding, resources, and staff for the Compliance Officer to fully perform their responsibilities,
- Ensuring that the County 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, and
- Advocating for the adoption and implementation of required modifications to the County's Compliance Program.

Membership: The County's Compliance Committee shall consist of the County's Compliance Officer and such other members as shall be appointed by the Chief Executive. Additional members appointed to the Compliance Committee shall, at a minimum, be senior managers. The Chair of the Committee shall be designated on an annual basis. At all times, the County shall maintain a list of Compliance Committee members including their names, titles, and dates of service on the Committee.

Meetings: The Compliance Committee shall meet on at least a quarterly basis (or more often as necessary) to review the Compliance Program and activities. At each meeting, the Compliance Committee shall receive a report from the Compliance Officer on the progress of adopting, implementing, and maintaining the County's Compliance Program. At the first meeting of each year, Committee members and a Chair shall be designated. The Compliance Officer or other members of the Compliance Committee can call additional meetings as needed to address issues requiring immediate remediation. Meeting minutes shall be taken at all Compliance Committee meetings and include date, location, members present, agenda items, summary of reports and action/next steps. Said meeting minutes shall be retained for a period of six (6) years from the date of the Compliance Committee meeting.

Compliance Committee Charter: The duties, responsibilities, membership, designation of a chair, and frequency of meetings of the Compliance Committee is outlined in the County's Compliance Committee Charter. The Compliance Committee will review and update the Compliance Committee Charter on at least an annual basis. The Compliance Committee shall maintain records of each annual Compliance

Committee Charter review evidencing the date of the review and a description of any updates. These records shall be retained for a period of six (6) years from the date of the review.

Reporting and Accountability: The Compliance Committee will report directly to, and will be accountable to, the County's Chief Executive and Governing Body.

IV. Training and Education

Applicability

All Affected Individuals—including employees and Board members of the Mental Health and Public Health Departments as well as all Legislators and contractors—shall participate in training and education on the Compliance Program, including the Code of Conduct. All training shall be in a form and format accessible and understandable to all Affected Individuals, consistent with federal and state language and other access laws, rules, or policies.

Frequency

Training shall occur at least annually for existing Affected Individuals. Training shall also be made a part of the orientation of new Affected Individuals (including the County's Compliance Officer), and shall occur promptly upon hiring (or initiation of relationship with the County) within 30 days.

Records of Training

The County Compliance Officer shall ensure that records of training are maintained, including copies of training materials, dates of training, and the individuals in attendance for a period of ten (10) years from the date of training.

Training Topics

Training programs will include an overview of all elements of the County's Compliance Program and will include, at a minimum, a discussion of the following topics:

- The County's Compliance Risk Areas and Organizational Experience;
- The County's written policies and procedures related to its Compliance Plan and Compliance Program;
- The role of the Compliance Officer and the Compliance Committee;
- How Affected Individuals can ask questions and report potential compliance-related issues to the Compliance Officer and senior management;
- The obligation of Affected Individuals to report suspected illegal or improper conduct and the procedures of submitting such reports;
- The protection from intimidation and retaliation for good faith participation in the Compliance Program;

- The County's disciplinary standards, with an emphasis on those standards related to the County's Compliance Program and prevention of fraud, waste, and abuse;
- How the County responds to compliance issues and implements corrective action plans;
- Requirements specific to the Medicaid Program and the County's categories of service (*i.e.*, those categories of service in which the County is enrolled in the Medicaid Program);
- Coding and billing requirements, if applicable; and
- The claim development and the submission process, if applicable.

Training Plan

The Compliance Officer, with the assistance of the Director of Human Resources or their designee, shall be responsible for developing and maintaining a compliance training plan. The training plan will, at a minimum, outline the following:

- The subjects or topics for training and education;
- The timing and frequency of the training;
- Which Affected Individuals are required to attend;
- How attendance is tracked; and
- How the effectiveness of the training will be periodically evaluated (*e.g.*, pre- and post-tests, surveys, etc.).

The training plan shall be periodically updated by the Compliance Officer, with the assistance of the Director of Human Resources or their designee, to indicate the outcome of the various trainings provided by the County throughout the year. These periodic updates will include the following information, as applicable:

- A list of the Affected Individuals that received, or did not receive, the Compliance Program training during the year covering the training plan including the name and role of the individual (*e.g.*, employee, senior administrator, manager, contractor, etc.);
- The type of compliance training(s) received (*e.g.*, annual, orientation, both);
- The format in which the training was provided;
- The date(s) of completion; and
- The date of hire for those who received initial Compliance Program training.

Periodic Review of Training

The County Compliance Officer and Compliance Committee shall periodically monitor, evaluate, and assess the content and effectiveness of the training materials and shall revise such training materials as necessary.

Distribution of Compliance Information

In addition to periodic training, the Compliance Officer will distribute any new compliance information to Compliance Committee members and Affected Individuals. This may include updates to the Compliance Plan, updated compliance contact information, etc.

Distribution and Certification of Plan

A copy of the adopted Compliance Plan is available on the Genesee County Internet and Intranet sites for access by all Affected Individuals, as well as the public. Notice as to where publication of the Compliance Plan is located shall be included in all new employees' orientation training packets. In addition, a Compliance Program poster shall be posted conspicuously and provided to all Medicaid and Medicaid Managed Care recipients to assist with communication of policy and procedures of the program, as well as the Compliance Hotline number for reporting concerns and misconduct.

V. Reporting Compliance Issues

Required Reporting

Genesee County has established a compliance reporting system where submissions are monitored and controlled exclusively by appropriate compliance personnel. If any Affected Individuals believe in good faith that fraud, waste, abuse or other improper conduct has occurred in violation of laws, rules, regulations, policies, or standards, or the County's Compliance Plan, policies, procedures, or Code of Conduct, the individual is required to report such information to the Compliance Officer or as set forth below. Individuals who report such conduct in good faith shall not be retaliated against or intimidated for making such a report. The County shall maintain the confidentiality of persons reporting compliance issues, regardless of whether confidentiality or anonymity is requested, unless the matter is subject to a disciplinary proceeding, referred to or under investigation by the New York State Attorney General Medicaid Fraud Control Unit, the New York State Office of the Medicaid Inspector General, or law enforcement, or disclosure is required during a legal proceeding. An individual may report a concern either directly or in writing to:

- Their Supervisor or Department Head
- Public Health Director
- Mental Health Director
- County Compliance Officer
- Legislative Compliance Committee Liaison
- County Manager or Assistant County Manager
- In writing addressed to Compliance Officer, Genesee County, 7 Main Street, Batavia, NY 14020
- Local Fraud Hotline 585-815-7830
- NYS Fraud Hotline 1-877-873-7283

Anonymous Reporting

The County has methods for anonymous reporting of potential fraud, waste, and abuse and compliance issues directly to the Compliance Officer. Anonymous reports can be made using the following reporting methods: written reports sent to Compliance Officer, Genesee County, 7 Main Street, Batavia, NY 14020, Anonymous Fraud Hotline (585) 815-7830.

Confidentiality

Any individual who reports a compliance concern in good faith will have the right to do so anonymously if they request anonymity. The confidentiality of persons reporting compliance issues shall be maintained, regardless of whether the individual has requested confidentiality or reported through an anonymous reporting mechanism, unless the matter is subject to disciplinary proceeding, referred to or under investigation by the New York State Attorney General Medicaid Fraud Control Unit, New York State Office of the Medicaid Inspector General or law enforcement, or disclosure is required during a legal proceeding. The information provided by the individual will be treated as confidential and privileged to the extent feasible and permitted by applicable laws. However, individuals who report compliance concerns are encouraged to identify themselves when making such reports so that an investigation can be conducted with a full factual background and without any delay.

Non-Retaliation and Non-Intimidation

Any individual—including Affected Individuals and Medicaid Program beneficiaries who receive services from the County—who participates in the County's Compliance Program in good faith will be protected against retaliation and intimidation. Conduct protected from intimidation and retaliation include, but are not limited to, the following:

- Reporting potential compliance issues to appropriate personnel;
- Participating in investigations of compliance issues;
- Self-evaluations;
- Audits;
- Remedial actions;
- Reporting instances of intimidation or retaliation; and
- Reporting potential fraud, waste, or abuse to the appropriate state or federal entities.

In such an instance, retaliation is itself is unlawful, and will not be tolerated. However, if the individual who reports the compliance issue has participated in a violation of law, rule, regulation, policy, or standard, or the County's Code of Conduct, policies, procedures, or Compliance Program, the County retains the right to take appropriate disciplinary or other action, up to and including termination of employment or in the case of a contractor, termination of the applicable contract.

In addition to the non-intimidation and non-retaliation protections afforded to Affected Individuals and Medicaid Program beneficiaries who receive services from the County, employees are also protected

from retaliatory action for good faith reporting under Sections 740 and 741 of the New York State Labor Law.

Publication of Lines of Communication

The County publicizes its lines of communication to the Compliance Officer and ensures that these lines of communication are available to all service recipients who are Medicaid Program beneficiaries and to all Affected Individuals. The County makes information regarding its Compliance Program and Code of Conduct, including its lines of communication for reporting compliance issues, available on its website.

VI. Responding to Compliance Issues

Investigation of Reports

Upon receiving a credible report of suspected or actual fraud, waste, abuse or other improper conduct or upon the identification of a potential or actual compliance problem in the course of self-evaluation and audits (including internal and external auditing and monitoring), the Compliance Officer will promptly investigate such report or problem through internal compliance processes, and involve outside counsel, auditors, or other experts to assist in an investigation, as appropriate and necessary. The purpose of the investigation will be to determine whether any corrective action is required. The County requires that all Affected Individuals fully cooperate in any such investigations. The investigative file should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and reviewed documents, the results of the investigation, any disciplinary and/or corrective action plan, and all other documents essential for demonstrating that a thorough investigation of the issue was conducted. All investigative records will be retained for a period of six (6) years from the conclusion of the investigation.

Corrective Action

After appropriate investigation, if the Compliance Officer determines that there has been an occurrence(s) of fraud, waste, abuse, improper conduct or violation(s) of the Code of Conduct, Compliance Program, the County's policies and procedures, or any applicable laws, rules, regulations, policies, or standards, the Compliance Officer shall institute a corrective action. Any problems identified shall be corrected promptly and thoroughly, and procedures, policies, and systems shall be implemented as necessary to reduce the potential for recurrence. If the County identifies credible evidence or credibly believes that a state or federal regulation, rule or law was violated, a report shall be promptly made to the appropriate government entity, where such reporting is otherwise required by law, rule, or regulation. The Compliance Officer shall receive copies of any reports submitted to governmental entities.

Disciplinary Action

Policies and procedures regarding disciplinary standards and enforcement shall be published and provided to all affected individuals and will be incorporated into required training. After appropriate investigation, if the Compliance Officer determines that there has been an occurrence(s) of fraud, waste, abuse, improper conduct or violation(s) of the Code of Conduct, Compliance Program, the County's policies and procedure, or any applicable laws, rules, regulations, policies, or standards, the Compliance

Officer in conjunction with the Human Resources Director or their designee, shall impose sanctions against those individuals involved. Sanctions shall be imposed for: (1) failing to report suspected problems; (2) participating in non-compliant behavior; and (3) encouraging, directing, facilitating or permitting non-compliant behavior.

Escalating disciplinary actions shall be taken in response to non-compliance, with intentional or reckless behavior being subject to more significant sanctions. Sanctions may include, but not be limited to, oral or written warnings, suspension, and/or termination. Sanctions and disciplinary standards shall be fairly and consistently applied and enforced, and the same disciplinary action will apply to all levels of personnel. Sanctions may be imposed against Department Heads and Supervisors for failure to adequately instruct employees on the importance of the detection of noncompliance with policies and legal requirements, where reasonable due diligence would have led to earlier discovery of a violation and opportunity to correct the problem. The County's disciplinary procedures shall conform with collective bargaining agreements, when applicable.

VII. Monitoring, Auditing and Exclusion Procedures

Risk Assessment and Auditing Procedures

The Compliance Officer and Compliance Committee are responsible for ensuring that internal and, where necessary, external compliance auditing takes place on a regular basis. Compliance-related audits are conducted as a result of an investigation or as a proactive means of monitoring compliance in all areas of actual or potential risk. Internal and external audits are performed for the purposes of routine monitoring and identification of compliance risks, to evaluate the County's compliance with the requirements of the Medicaid Program, and to evaluate the overall effectiveness of the County's Compliance Program.

Risks will be identified and prioritized through periodic risk assessments performed by the Compliance Officer and/or Compliance Committee members. Areas addressed in risk assessments include the County's Compliance Risk Areas, including, for example, Medicaid billings and payments, the medical necessity and quality of care, mandatory reporting requirements, credentialing of those who are providing covered services, and other risk areas that relate to Medicaid funded services. The results of all internal or external audits, or audits of the County conducted by the state or federal government, will be reviewed for risk areas that can be included in updates to the County's Compliance Program and compliance work plan.

The Compliance Officer is primarily responsible for overseeing compliance auditing by internal and, where necessary, external means. This may include, but is not limited to, periodic and regularly scheduled reviews of documentation, billing, claims processing, and reimbursement procedures, quality of services, accounting practices, as well as practices that are mandated by County and individual department policies and procedures, to ensure adherence with federal and state laws, rules, regulations, policies, and standards, as well as Medicaid Program and other health care payer requirements. Routine internal and/or external audits will be performed by internal or external auditors who have expertise in state and federal Medicaid Program requirements and applicable laws, rules, and regulations, or who have expertise in the subject area of the audit.

Audit design, implementation, findings and recommendations of all internal or external audits are documented, and are reported to the Compliance Committee and County Legislature. As needed or requested, corrective action plans will be completed by the Compliance Officer or Management and incorporated into the final audit report.

Corrective Action Plans

The Compliance Officer and/or Compliance Committee shall receive and review the results audits, develop a corrective action plan to remedy any deficiencies identified in the results, and provide the corrective action plan to those individuals who will be charged with the responsibility of implementing it. If periodic review and monitoring activities identify substantial deviation from acceptable norms, the Compliance Officer, Compliance Committee, Covered Department, and Genesee County Legislature shall take prompt steps to address such deviations. The County shall ensure that any Medicaid Program overpayments identified through its auditing and monitoring activities are reported, returned, and explained in accordance with applicable regulations, and that corrective action to prevent recurrence is promptly taken.

Exclusion Procedures

The County shall conduct exclusion screening to determine the exclusion status of all Affected Individuals. These exclusion checks will be completed using the County's subscription to K-Checks Automated Exclusion Management System. It will automatically search a central repository on a monthly basis (every thirty (30) days) for individuals and entities that have been excluded from participating in federally funded healthcare programs including Medicaid and Medicare. In regards to K-Checks:

- The Compliance Officer will be responsible for inputting new Affected Individuals and deleting terminated Affected Individuals who no longer provide services to the County from the system on a monthly basis.
- Matches will be cleared by the Compliance Officer or another member of Management on a monthly basis. This involves determining if any matches are in fact Affected Individuals.
- All matches will be investigated further by appropriate Management personnel with assistance from the Compliance Officer and Compliance Committee.
- If excluded provider information is accurate and cannot be resolved, disciplinary action up to and including termination may be taken in accordance with the applicable union labor agreement, collective bargaining agreement, or New York State Civil Service Law § 75, where applicable.
- At least the following state and federal databases will be reviewed at least every thirty (30) days: (1) the New York State Office of the Medicaid Inspector General Exclusion List; and (2) the U.S. Department of Health and Human Services Office of Inspector General's List fo Excluded Individuals and Entities.

Contracts and agreements with contractors shall specify that the contractor is required to comply with the exclusion verification requirements set out in the Compliance Regulations.

VIII. Compliance Contacts and Numbers

Compliance Officer	(585) 344-2550 ext. 2212
Compliance Committee Legislative Liaison	(585) 344-2550 ext. 2202
County Manager	(585) 344-2550 ext. 2204
Local Fraud Hotline	(585) 815-7830
NYS Fraud Hotline	(877) 873-7283

IX. Program Evaluation

The Compliance Officer will oversee a review of the Compliance Program on at least an annual basis to determine whether the requirements set out in the Compliance Regulations have been met. The purpose of the annual review will be to determine:

- The effectiveness of the Compliance Program;
- Whether any revision or corrective action is required;
- Whether the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the Compliance Program; and
- Whether the Compliance Officer was able to satisfactorily perform their responsibilities for the day-to-day operation of the Compliance Program, including whether the Compliance Officer's other duties hindered the Compliance Officer in carrying out their primary responsibilities, if applicable.

The annual review may be carried out by the Compliance Officer, Compliance Committee, external auditors, or other staff designated by the County, so long as the other staff 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 Compliance Officer will randomly survey Affected Individuals as to their knowledge and understanding of the Program. Additionally, the annual reviews will include on-site visits, interviews with Affected Individuals, review of records and surveys, and any other comparable method deemed appropriate by the County, provided that such method does not compromise the independence or integrity of the review. The design, implementation, and results of the effectiveness review, and any corrective action implemented, will be documented, and the results of the annual reviews will be shared with the County's Chief Executive, senior management, Compliance Committee, and the Governing Body.

X. Work Plan

Each year, the Compliance Officer and Compliance Committee will develop a Compliance Work Plan. The Compliance Work Plan will outline the County's proposed strategy for meeting the requirements set out in the Compliance Regulations for the coming year, and will include a specific emphasis on written policies

and procedures, training and education, auditing and monitoring, and responding to compliance issues. The Compliance Officer will review accomplishments from the prior year plan and propose updated amendments to existing compliance policy procedures and practices. The Work Plan will be drafted, implemented, and updated by the Compliance Officer at least annually, or as otherwise necessary, to conform to changes in federal and state laws, rules, regulations, policies, and standards.

The Compliance Officer is responsible for coordinating the implementation of the Work Plan, although others may be involved in completing the activities identified in the Work Plan. Progress in regards to the compliance Work Plan will be tracked at the quarterly Compliance Committee meetings. The Compliance Officer will report to the Compliance Committee, Chief Executive, and County Legislature quarterly on work plan activity.

XI. Record Retention

The County shall retain all records demonstrating that it has adopted, implemented, and operated an Effective Compliance Program and has satisfied the requirements of the Compliance Regulations. These records will be retained by the County for a period of not less than six (6) years from the date the Compliance Program was implemented or any amendments to the Program were made, unless a longer retention period is required by a specific County policy or procedure. The County shall make copies of these records available to the New York State Department of Health, the New York State Office of the Medicaid Inspector General, or the New York State Attorney General Medicaid Fraud Control Unit upon request.

XII. Contract Requirements

The County shall ensure that contract with contractors—including contractors, agents, subcontractors, and independent contractors—specify that the contractors are subject to the County's Compliance Program, to the extent that the contractors are affected by the County's Compliance Risk Areas and only within the scope of their contracted authority and affected Compliance Risk Areas. The County shall also ensure that such contracts include termination provisions for failure to adhere to the County's Compliance Program requirements. Finally, the County will also ensure that contractors are required to comply with applicable exclusion screening requirements.

XIII. Written Policies and Procedures

Written Policies and Procedures

The County maintains written policies, procedures, and a Code of Conduct applicable to its Compliance Program (the "Compliance Policies.") The County's Compliance Policies shall be available, accessible, and applicable to all Affected Individuals. The Compliance Policies shall:

- Articulate the County's commitment and obligation to comply with all applicable federal and state laws, rules, regulations, guidance and other standards;

- Identify governing laws and regulations applicable to the County's Compliance Risk Areas, including any applicable Medicaid Program policies and procedures for its categories of service;
- Describe the County's compliance expectations as embodied in its Code of Conduct, which shall serve as a foundational document which describes the County's fundamental principles and values, and commitment to conduct its business in an ethical manner;
- Document the implementation of each of the requirements set out in the Compliance Regulations, and outline the County's ongoing operation of its Compliance Program;
- Describe, at a minimum, the structure of the County's Compliance Program, including the responsibilities of all Affected Individuals in carrying out the Compliance Program's functions;
- Provide guidance to Affected Individuals on dealing with potential compliance issues, including assisting Affected Individuals in identifying potential compliance issues, questions and concerns, expectations for reporting compliance issues, and how to report compliance issues, questions, and concerns to the County's Compliance Officer;
- Establish the County's expectation that all Affected Individuals will act in accordance with its Code of Conduct, must refuse to participate in illegal or unethical conduct, and must report unethical or illegal conduct to the Compliance Officer;
- Identify the methods and procedures for communicating compliance issues to the Compliance Officer and other appropriate parties at the County;
- Describe how potential compliance issues are investigated and resolved by the County, and the procedures for documenting the investigation and the resolution or outcome;
- Include a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Program, including, but not limited to reporting potential compliance issues to the Compliance Officer or other appropriate parties at the County, participating in investigations of potential compliance issues, self-evaluations, audits, remedial actions, reporting instances of intimidation or retaliation, and reporting potential fraud, waste, or abuse to the appropriate state or federal entities;
- Set out the County's policy regarding Affected Individuals who fail to comply with the Compliance Policies and state and federal laws, rules, and regulations; and
- Set out detailed information about the False Claims Act, federal administrative remedies for false claims and statements, New York State laws pertaining to civil and criminal penalties for false claims and statements, and whistleblower protections under applicable laws, as well as detailed provisions related to detecting and preventing fraud, waste, and abuse.

Drafting the Compliance Policies

The County's Compliance Officer will be responsible for drafting the Compliance Policies. The Compliance Officer may delegate these duties to other appropriate personnel, as well as to outside attorneys and consultants, as necessary and appropriate. In all instances, the Compliance Officer will remain responsible for overseeing the drafting of the Compliance Policies. The County's Compliance

Committee will also be responsible for coordinating with the Compliance Officer to ensure that the Compliance Policies are current, accurate, and complete. A record of the implementation dates of the individual Compliance Policies will be maintained by the Compliance Officer.

Reviewing and Revising the Compliance Policies

The County's Compliance Officer will be responsible for reviewing and revising the Compliance Policies. The Compliance Officer, in consultation with appropriate personnel and legal counsel, as necessary, will determine whether the Compliance Policies should be revised based on changes to the County's Organizational Experience and/or changes to federal and state laws, rules regulations, policies, and standards. The Compliance Officer may delegate these duties to other appropriate personnel, as well as to outside attorneys and consultants, as necessary and appropriate. In all instances, the Compliance Officer will remain responsible for overseeing the reviewing and revising of the Compliance Policies. The County's Compliance Committee will also be responsible for coordinating with the Compliance Officer to ensure that the Compliance Policies are current, accurate, and complete. A record of the revision dates of the individual Compliance Policies will be maintained by the Compliance Officer.

Approval of the Compliance Policies

The County's Compliance Policies shall be reviewed and approved by the Compliance Committee, Chief Executive, and Governing Body. A record of the approval dates of the individual Compliance Policies will be maintained by the Compliance Officer.

Annual Review of the Compliance Policies

The County's Compliance Policies shall be reviewed on at least an annual basis. The Compliance Officer, in coordination with the Compliance Committee, will be responsible for completing this annual review. The Compliance Officer may seek the assistance of attorneys and consultants, as necessary and appropriate, in completing the annual review of the Compliance Policies. The purpose of the annual review will be to determine whether:

- The Compliance Policies have been implemented;
- Affected Individuals are following the Compliance Policies;
- The Compliance Policies are effective; and
- Any updated to the Compliance Policies are required.

The Compliance Officer will maintain documentation of the annual review of the Compliance Policies, including any updates to the individual Compliance Policies identified during the annual review.

Availability and Accessibility of the Compliance Policies

The County's Compliance Policies shall be available and accessible to all Affected Individuals. A copy of the adopted Compliance Plan is available on the Genesee County Internet and Intranet sites for access by all Affected Individuals, as well as the public. Notice as to where publication of the Compliance Plan is located shall be included in all new employees' orientation training packets. In addition, a Compliance Program poster shall be posted conspicuously and provided to all Medicaid and Medicaid Managed Care

recipients to assist with communication of policy and procedures of the program, as well as the Compliance Hotline number for reporting concerns and misconduct.

The Compliance Policies will be published and disseminated to all Affected Individuals at hiring or time of contracting, on at least an annual basis, and whenever changes to the Compliance Policies are made, and documentation of this distribution will be maintained by the Compliance Officer. Information on the Compliance Policies will also be incorporated into the County's compliance training and education program and compliance training plan.

XIV. Laws Regarding the Prevention of Fraud, Waste and Abuse[1]

Federal Laws

False Claims Act (31 USC §§ 3729 – 3733; 18 USC § 287): Under the Federal Civil False Claims Act, any person who knowingly and/or willfully submits a false or fraudulent claim for payment to the Federal government may be subject to civil penalties, including monetary penalties, treble damages, exclusion from participation in the Medicare and Medicaid Programs, and fines of up to three times the government's loss plus up to $11,000 per claim filed (*i.e.*, each instance of an item or service billed to a government health care program). Examples of prohibited conduct include billing for services not rendered, upcoding claims, double billing, misrepresenting services that were rendered, falsely certifying that services were medically necessary, making false statements to the government, failing to comply with conditions of payment, and failing to refund overpayments made by a Federal health care program. Notably, no specific intent to defraud the government is required, as "knowing" is defined to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. The civil False Claims Act also contains a whistleblower provision that permits private citizens ("relators") to file suits on behalf of the government ("*qui tam* suits") against those who have defrauded the government and the relator, if successful, may receive a portion of the government's recovery.

Federal law also establishes criminal liability against individuals or entities that knowingly submit, or cause to be submitted, a false or fraudulent claim for payment to the Federal government. Criminal False Claims Act liability can result in imprisonment of up to five years and/or substantial fines.

Administrative Remedies for False Claims (31 USC §§ 3801 – 3812): Federal law allows for administrative recoveries by Federal agencies related to false claims. The laws penalize any person who makes, presents, or submits (or causes to be made, presented, or submitted) a claim that the person knows or has reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

[1] These are summaries of very complex laws. The Compliance Officer can provide more information about these laws, or their application to a situation that may be encountered. These laws all serve the important function of protecting the Federal and State health care programs from fraud, waste, and abuse and allow those funds to protect the beneficiaries of these programs. Genesee County supports the goals of these laws and requires all employees, contractors and agents to comply with these laws as part of our mission of providing services to individuals.

- Includes or is supported by any written statement that omits a material fact, is false, fictitious, or fraudulent as a result of such omission, and is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or
- Is for payment for the provision of property or services which the person has not provided as claimed.

The Federal agency receiving the false claim may impose a penalty of up to $5,000 for each claim, as well as an assessment of up to twice the amount of the claim in violation of the False Claims Act. In these instances, the determination of whether a claim is false and the imposition of fines and penalties is made by the Federal administrative agency, rather than by a court. Moreover, in contrast to the False Claims Act, a violation of these laws occurs when a false claim is submitted, rather than when it is paid.

Anti-Kickback Statute (42 USC § 1320a-7b(b)): The Federal Anti-Kickback Statute is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service that is payable by a Federal health care program. Remuneration includes kickbacks, bribes, and rebates paid director or indirectly, overtly or covertly, in cash or in kind (*i.e.*, anything of value), and items or services includes drugs, supplies, or health care services provided to Medicare or Medicaid patients. The Statute covers both the payers and recipients of kickbacks. No intent to violate the Statute is required, and the Statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.

An individual or entity that is found to have violated the Anti-Kickback Statute may be subject to criminal penalties and administrative sanctions including fines, imprisonment, and exclusion from participation in Federal health care programs, including the Medicaid and Medicare Programs. Safe harbors protect certain payment and business practices from criminal and civil prosecution that could otherwise implicate the Anti-Kickback Statute. To be protected by a safe harbor, the arrangement must fit squarely within the safe harbor and must satisfy all of its requirements.

Physician Self-Referral Law (42 USC § 1395nn): The Federal Physician Self-Referral Law, commonly referred to as the "Stark Law," prohibits physicians—including medical doctors, doctors of osteopathy, psychologists, oral surgeons, dentists, podiatrists, optometrists, and chiropractors—from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless the ownership or compensation arrangement is structured to fit within a regulatory exception.

Financial relationships include both ownership/investment interests and compensation arrangements, and "designated health services" are any of the following services, other than those provided as emergency physician services furnished outside of the United States, that are payable in whole or in part by the Medicare Program:

- Clinical laboratory services;
- Physical therapy, occupational therapy, and outpatient speech-language pathology services;
- Radiology and certain other imaging services;

- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

The Stark Law is a strict liability statute, and therefore, proof of specific intent to violate the law is not required. The Law also prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark Law include fines, civil penalties, repayment of Medicare and/or Medicaid reimbursement, and exclusion from participation in the Federal health care programs.

Exclusion Statute (42 USC § 1320a-7): The Federal Exclusion Statute requires the U.S. Department of Health and Human Services Office of Inspector General to exclude individuals and entities convicted of certain types of criminal offenses from participation in all Federal health care programs (including the Medicare and Medicaid Programs), and gives the Office the discretion to exclude individuals and entities on several other grounds. The following types of criminal offenses require exclusion:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid;
- Patient abuse or neglect;
- Felony convictions for other health-care-related fraud, theft, or other financial misconduct; and
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Physicians who are excluded from participation in Federal health care programs are barred from receiving payment from programs such as Medicaid and Medicare for items or services furnished, ordered, or prescribed. Additionally, individuals and entities providing health care services may not employ or contract with excluded individuals or entities in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors. Employing or contracting with an excluded individual or entity may result in civil monetary penalties and an obligation to repay any amounts paid by a Federal health care program attributable to the excluded individual or entity’s services.

Civil Monetary Penalties Law (42 USC § 1320a-7a): The Federal Civil Monetary Penalties Law authorizes the U.S. Department of Health and Human Services Office of Inspector General to seek civil monetary and other penalties against individuals and entities for a wide variety of conduct, including presenting a claim that a person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent, presenting a claim that the person knows or should know is for an item

or service that is not payable, or making false statements or misrepresentations on applications or contracts to participate in Federal health care programs, among others. Violations of the False Claims Act, Anti-Kickback Statute, and Stark Law implicate the Civil Monetary Penalties Law and can lead to civil monetary and other penalties.

The amount of the penalties and assessments that the U.S. Department of Health and Human Services Office of Inspector General is authorized to seek under the Civil Monetary Penalties Law differs depending on the type of violation at issue. Specifically, the Civil Monetary Penalties Law authorizes penalties in the amount of $100,000 for each act in violation of the Anti-Kickback Statute, in addition to any other penalty that may be prescribed by law. Regulations also permit the U.S. Department of Health and Human Services Office of Inspector General to impose a penalty up to $50,000 for each offer, payment, solicitation or receipt of remuneration, and violations of the Anti-Kickback Statute can result in assessments of up to three times the total amount of the remuneration offered, paid, solicited, or received. Remuneration under the Civil Monetary Penalties Law includes waivers of coinsurance and deductible amounts (including partial waivers), and transfers of items or services for free or for amounts other than fair market value. In addition to civil monetary penalties, persons or entities may also be excluded from participation in Federal health care programs, fines, treble damages, denial of payment, and repayment of amounts improperly paid.

New York State Laws

New York State False Claims Act (N.Y. State Finance Law §§ 187 – 194): The New York State False Claims Act closely tracks the Federal False Claims Act, and imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any State or local government, including health care programs such as the Medicaid Program. Specifically, the Act penalizes any person or entity who, among other conduct:

- Knowingly presents, or causes to be presented, to any employee, officer, or agent of the State or a local government a false or fraudulent claim for payment or approval, or conspires to do the same;
- Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim, or conspires to do the same;
- Conspires to defraud the State or a local government by getting a false or fraudulent claim allowed or paid; or
- Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State or a local government.

The penalty for filing a false claim is $6,000 to $12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the person or entity that filed the false claim may have to pay the government's legal fees, including the costs of a civil action brought to recover any penalties or damages and attorneys' fees. The New York State False Claims Act also allows private individuals ("relators") to bring an action on behalf of the State or local government ("*qui tam* suits"). If the lawsuit results in a recovery or settlement, the relator may share in a percentage of the proceeds.

New York Social Services Law § 145: Under Section 145 of the New York Social Services Law, any person who makes false statements or representations, deliberately conceals any material fact, impersonates another, or through another fraudulent device obtains, or attempts to obtain, or aids or abets any person to obtain, public assistance or care to which the person is not entitled, including Medicaid Program benefits, is guilty of a misdemeanor. However, if the act constitutes a violation of a provision of the New York Penal Law, the person will be punished in accordance with the penalties fixed by the applicable law.

New York Social Service Law § 145-b: Section 145-b of the New York Social Services Law makes it unlawful to knowingly make a false statement or representation, to deliberately conceal any material fact, or to engage in any other fraudulent scheme or device to obtain or attempt to obtain public funds, including Medicaid Program funds. In instances where a violation of this law occurs, the local Social Services District or the State may recover civil damages equal to three times the amount by which any figure is falsely overstated. In the case of non-monetary false statements, the local Social Services District or State may recover three times the damages sustained by the government due to the violation or $5,000, whichever is greater. The Department of Health may also impose a civil penalty of up to $2,000 per violation, and if repeat violations occur within five years, a penalty of up to $7,500 per violation may be imposed if the conduct involves more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

New York Social Services Law § 145-c: Under Section 145-c of the New York Social Services Law, any person who applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the person or their family are not taken into account for various periods of time based on the offense committed. Specifically, the person's or their family's needs will not be taken into account for six months on the first offense, 12 months on the second offense or a single offense that resulting in the wrongful receipt of benefits in an amount of between $1,000 and $3,900, 18 months on the third offense or upon an offense that results in the wrongful receipt of benefits in an amount in excess of $3,900, and five years for any subsequent occasion of any such offense. These sanctions are in addition to any sanctions which may be provided for by law with respect to the offenses involved.

New York Social Services Law § 366-b: Under Section 366-b of the Social Services Law, any person who obtains or attempts to obtain, for themselves 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. Additionally, 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. Finally, if an act also constitutes a violation of a provision under the New York Penal Law, the person committing the act will be punished in accordance with the penalties fixed by such law.

New York Penal Law Article 155: Article 155 of the New York Penal Law establishes the crime of Larceny, which occurs when a person, with intent to deprive another of their property, obtains, takes, or withholds the property by means of trick, embezzlement, false pretense, false promise, a scheme to

defraud, or other similar behavior. The four crimes of Larceny have been applied to Medicaid fraud cases. These crimes include:

- Penal Law § 155.30, Grand Larceny in the Fourth Degree, which involves property valued over $1,000, and is a Class E felony;
- Penal Law § 155.35, Grand Larceny in the Third Degree, which involves property valued over $3,000, and is a Class D felony;
- Penal Law § 155.40, Grand Larceny in the Second Degree, which involves property valued over $50,000, and is a Class C felony; and
- Penal Law § 155.42, Grand Larceny in the First Degree, which involves property valued over $1 million, and is a Class B felony.

New York Penal Law Article 175: The four crimes in Article 175 of the New York Penal Law, Offenses Involving False Written Statements, relate to filing false information or claims and have been applied in Medicaid fraud prosecutions. These crimes include:

- Penal Law § 175.05, Falsifying Business Records, which involves entering false information, omitting material information, or altering an enterprise's business records with the intent to defraud, and is a Class A misdemeanor;
- Penal Law § 175.10, Falsifying Business Records in the First Degree, which includes the elements of Penal Law § 175.05 and the intent to commit another crime or conceal its commission, and is a Class E felony;
- Penal Law § 175.30, Offering a False Instrument for Filings in the Second Degree, involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information, and is a Class A misdemeanor; and
- Penal Law § 175.35, Offering a False Instrument for Filing in the First Degree, which includes the elements of Penal Law § 175.30 and an intent to defraud the State or a political subdivision, and is a Class E Felony.

New York Penal Law Article 176: Article 176 of the New York Penal Law, Insurance Fraud, applies to claims for insurance payment, including Medicaid or other health insurance, and contains six crimes. The crimes include:

- Penal Law § 176.10, Insurance Fraud in the Fifth Degree, which involves intentionally filing a health insurance claim knowing that it is false, and is a Class A misdemeanor;
- Penal Law § 176.15, Insurance fraud in the Fourth Degree, which involves filing a false insurance claim for over $1,000, and is a Class E felony;
- Penal Law § 176.20, Insurance Fraud in the Third Degree, which involves filing a false insurance claim for over $3,000, and is a Class D felony;
- Penal Law § 176.25, Insurance Fraud in the Second Degree, which involves filing a false insurance claim for over $50,000, and is a Class C felony; and

- Penal Law § 176.30, Insurance Fraud in the First Degree, which involves filing a false insurance claim for over $1 million, and is a Class B felony;
- Penal Law § 176.35, Aggravated Insurance Fraud, which involves committing insurance fraud more than once, and is a Class D felony.

New York Penal Law Article 177: Article 177 of the New York Penal Law establishes the crime of Health Care Fraud, and applies to claims for health insurance payment, including claims submitted to the Medicaid Program and other health plans, including non-government plans, and contains five crimes. The crimes include:

- Penal Law § 177.05, Health Care Fraud in the Fifth Degree, involves knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions, and is a Class A misdemeanor;
- Penal Law § 177.10, Health Care Fraud in the Fourth Degree, involves filing false claims and annually receiving over $3,000 in the aggregate, and is a Class E felony;
- Penal Law § 177.15, Health Care Fraud in the Third Degree, involves filing false claims and annually receiving over $10,000 in the aggregate, and is a Class D felony;
- Penal Law § 177.20, Health Care Fraud in the Second Degree, involves filing false claims and annually receiving over $50,000 in the aggregate, and is a Class C felony; and
- Penal Law § 177.25, Health Care Fraud in the First Degree, involves filing false claims and annually receiving over $1 million in the aggregate, and is a Class B felony.

Whistleblower Protections

Federal False Claims Act (31 USC §§ 3730(h)): The civil False Claims Act provides protection to 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 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. However, if the *qui tam* action has no merit or is for the purpose of harassing the person or entity, the individual may have to pay the person or entity for its legal fees and costs in defending the suit.

New York State False Claims Act (N.Y. State Finance Law § 191): The New York State False Claims Act provides protection to an employee of any private or public employer who is discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against in the terms and conditions of employment by their employer because of lawful acts taken by the employee in furtherance of an action under the New York State False Claims Act. Remedies can include reinstatement to the same position or an equivalent position, two times back pay, reinstatement of full fringe benefits and seniority rights, and compensation for any special damages sustained, including litigation costs and reasonable attorneys' fees.
New York Labor Law § 740: An employer may not take any retaliatory action against an employee (including former employees) if the employee discloses, or threatens to disclose, information about the employer's policies, practices, or activities to a regulatory, law enforcement, or another similar agency

or public official. Protected disclosures include disclosures of an activity, policy, or practice of the employer that the employee reasonably believes are in violation of law, rule, or regulation, or that the employee reasonably believes pose a substantial and specific danger to the public health or safety. The employee's disclosure is protected only if the employee first raised the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. However, employer notification is not required where:

- There is an imminent and serious danger to the public health or safety;
- The employee reasonably believes that reporting to the supervisor would result in destruction of evidence or other concealment of the activity, policy, or practice;
- The activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor;
- The employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or
- The employee reasonably believes that the supervisor is already aware of the activity, policy, or practice and will not correct it.

Employees are also protected from retaliatory action if the employee objects to, or refuses to participate in, any activity that is in violation of law, rule, or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety. Additionally, employees are protected when the employee provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into an employer's activity, policy, or practice. If an employer takes retaliatory action against the employee, the employee may sue in State court for reinstatement to the same position held before the retaliatory action, or to an equivalent position, any back wages and benefits, and attorneys' fees, among other remedies. If the employer's violation was willful, malicious, or wanton, punitive damages may be imposed.

New York State Labor Law § 741: A health care employer may not take any retaliatory action against a health care employee if the health care employee discloses, or threatens to disclose, certain information about the health care employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official, to a news media outlet, or to a social media forum available to the public at large. Under the law, a "health care employee" is any person who performs health care services for, and under the control and director of, any public or private employer that provides health care services for wages or other remuneration.

Protected disclosures include disclosures of an activity, policy, or practice of the health care employer that the health care employee, in good faith, reasonably believes constitute improper quality of patient care or improper quality of workplace safety. Health care employees are also protected from retaliatory action if the health care employee objects to, or refuses to participate in, any activity, policy, or practice of the health care employer that the health care employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

The health care employee's disclosure is protected only if the health care employee first raised the matter with a supervisor and gave the health care employer a reasonable opportunity to correct the activity,

policy, or practice. However, employer notification is not required where the improper quality of patient care or workplace safety presents an imminent threat to public health or safety, to the health of a specific patient, or to the health of a specific health care employee and the health care employee reasonably believes, in good faith, that reporting to a supervisor would not result in corrective action.

If a health care employer takes retaliatory action against the health care employee, the health care employee may sue in State court for reinstatement to the same position held before the retaliatory action, or to an equivalent position, any back wages and benefits, and attorneys' fees, among other remedies. If the health care employer's violation was willful, malicious, or wanton, punitive damages may be imposed.

Glossary of Terms

Abuse – As defined in 18 NYCRR § 515.1(b)(1), abuse means practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs to the Medicaid Program, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care.

Affected Individuals – All persons who are affected by the County's Compliance Risk Areas including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors and governing bodies.

Agents – Any person or business that acts as a representative of or has the authority to act for or on behalf of the County.

Compliance Regulations – The regulations applicable to Compliance Programs found in 18 NYCRR Part 521-1, which set forth the requirements for establishing and operating effective Compliance Programs pursuant to Section 363-d of the Social Services Law.

Compliance Risk Areas – The areas of operation affected by the County's Compliance Program, including billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor, subcontractor, agent or independent contract oversight, and other risk areas that the County is or should reasonably be identified by the County through its Organizational Experience.

Effective Compliance Program – A Compliance Program adopted and implemented by the County that, at a minimum, satisfies the requirements of the Compliance Regulations and that is designed to be compatible with the County's characteristics (*i.e.*, size, complexity, resources, and culture), which shall mean that it: (1) is well-integrated into the County's operations and supported by the highest levels of the organization, including the chief executive, senior management, and governing bodies; (2) promotes adherence to the County's legal and ethical obligations; and (3) is reasonably designed and implemented to prevent, detect, and correct non-compliance with Medicaid Program requirements, including fraud, waste, and abuse most likely to occur for the County's Compliance Risk Areas and Organizational Experience.

Fraud – As defined in 18 NYCRR § 515.1(b)(7), fraud means an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person and include the acts prohibited by Section 366-b of the New York State Social Services Law.

Organizational Experience – The County's: (1) knowledge, skill, practice, and understanding in operating its Compliance Program; (2) identification of any issues or risk areas in the course of its internal monitoring and auditing activities; (3) experience, knowledge, skill, practice, and understanding of its participation in the Medicaid Program and the results of any audits, investigations, or reviews it has been the subject of; or (4) awareness of any issues it should have reasonably become aware of for its category or categories of service.

Waste – Generally defined as "the overutilization of services, or other practices that directly or indirectly result in unnecessary cost to the Medicaid program."