3-23-HH-12

RESOLUTION NO. 142-23 3/28/2022 HD CORP COMPLIANCE PLAN

Adopting a revised and restated Corporate Compliance Plan

BY: Elane Daly, Chair, Health and Human Services Committee

WHEREAS, the Cayuga County Legislature ("Legislature") is committed to preventing and reducing the potential for fraud, waste, and abuse in the processing of Medicare, Medicaid, and other third party-payor claims through the establishment of an effective audit and reporting structure that will enable and enhance the County's ability to self-correct and/or self-report errors; and

WHEREAS, by Resolution No. 499 - 2010, the Legislature adopted individual Compliance Plans for the Health Department, Human Services, Nursing Home and Community Mental Health Center and appointed a compliance committee to implement said plans; and

WHEREAS, the Compliance Plan was amended in 2019, after an external legal review with recommendations, and as a result, the Legislature adopted Resolution No. 115-2019, which authorized a centralized approach to its compliance efforts, adopting an overarching County-wide Corporate Compliance Plan and appointing a Corporate Compliance Officer to oversee the compliance activities conducted by the applicable Covered Departments; and

WHEREAS, in furtherance of the County's continuing efforts to improve and update its Compliance Plan, the Legislature finds that it is in the public interest to further revise the County's Corporate Compliance Plan consistent with recent personnel changes and to further enhance the centralized reporting and training functions incorporated into its compliance efforts; now therefore be it

RESOLVED, that the Legislature hereby ratifies its previous decision (Resolution No. 370-22) to designate the Cayuga County Operations Officer as the Compliance Officer to oversee the HIPAA Policy and in addition, to oversee the day-to-day implementation of the Corporate Compliance Plan throughout County operations in collaboration with the Departmental Compliance Officers and the Corporate Compliance Committee identified in the Plan; and be it further

RESOLVED, that the Cayuga County Legislature does hereby adopt the attached restated Corporate Compliance Plan to be added to the Cayuga County Policy Manual, and be it further

RESOLVED, that the Plan be posted on the County website as well as the County Portal and distributed by the Clerk of the Legislature to all Department Heads; and be it further

RESOLVED, that this resolution take effect immediately upon adoption.

State of New York }
County of Cayuga }

I do hereby certify, that I have compared the forgoing copy of a Resolution duly passed and adopted by the Cayuga County Legislature at a meeting held on the 28th day of March 2023 with the original Resolution, and that the same is a true and correct copy and transcript thereof, and the whole thereof.

Given under my hand and official seal March 29, 2023

Sheila P. Smith
CLERK, CAYUGA COUNTY LEGISLATURE

CAYUGA COUNTY

CORPORATE COMPLIANCE PLAN

CAYUGA COUNTY

CORPORATE COMPLIANCE PLAN

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Adopted: Res. No. 499-2010
Revised: Res. No. 115-2019
Revised: Res. No. ____-2023

CAYUGA COUNTY

CORPORATE COMPLIANCE PLAN

I. Introduction

A. *Overview.*

Cayuga County provides medical and health related services for which it receives payments from Medicare, Medicaid and third party-insurers. Such services are provided through the Cayuga County Community Mental Health Center ("CCCMHC") and the Health Department (collectively, "Covered Departments"). The County finds that it is in the public interest to establish a "corporate" (meaning throughout County government) compliance program to ensure that quality medical and health related services are provided in a manner that fully conforms to all applicable state and federal laws and regulations. To meet this goal, Cayuga County hereby establishes the within Corporate Compliance Plan to create an internal audit and reporting structure to reduce the potential for fraud, waste, and abuse through self-correction and/or self-reporting of errors and to assist its departmental staff in adhering to state and federal law, and health care program requirements, while conducting services in the highest ethical manner.

Cayuga County is committed to detection, prevention, and resolution of instances of conduct that do not conform to federal, state and county laws, rules, and regulations, payor Plan requirements and the County's business practices. The goals of the Compliance Program are to:

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

inappropriate activities,

- Develop policies and procedures to oversee medical necessity and quality of care, and
- Assure appropriate credentialing and exclusion controls are in place.

The County's Compliance Plan applies to all: (1) individuals employed by the Covered Departments; (2) individuals and entities providing services and supplies to the Covered Departments; and (3) members of the Cayuga County Board of Health and the Cayuga County Legislature, ("Covered Persons"). All Covered Persons are expected to read, understand and comply with this Compliance Plan (including the Code of Conduct). In addition, all Covered Persons are expected to report any conduct that they believe violates this Plan, the County's policies, or applicable laws and regulations to their supervisor, the County Compliance Officer, or the County Compliance Hotline.

B. *Definitions.*

The following definitions shall apply to this Corporate Compliance Plan:

1.) "Covered Department" shall mean a County department or administrative unit that directly provides medical assistance to members of the public, as defined by Social Services Law § 363-d, including the Mental Health Department and the Public Health Department.

2.) "Covered Person" shall be deemed to include each employee within a Covered Department; any volunteer providing services to such Covered Department; each member of any board or committee that governs, supervises, oversees or advises such Covered Department (whether such member serves by reason of appointment, election or as a volunteer); any County employee who is responsible for managing, supervising, or overseeing a Covered Person whether or not employed within a Covered Department; and any contractor or vendor who provides services to or for the benefit of a Covered Department.

3.) "Corporate Compliance Committee" (CCC) shall mean the Committee established under this within Policy and shall be comprised of the Corporate Compliance Officer, the Public Health Director (or designee), the Director of Community Services (or designee), the County Attorney (or designee), and each of the respective Departmental Compliance Officers. The Corporate Compliance Officer shall serve as chair of the CCC.

4.) "Corporate Compliance Officer" (CCO) shall mean the Cayuga County Operations

Officer, who in his or her capacity as the Chair of the CCC, shall be responsible for overseeing the day-to-day implementation of the Corporate Compliance Plan throughout County operations.

5.) "Departmental Compliance Officer" (DCO) shall mean the compliance officer appointed by a Covered Department who shall be responsible for the day-to-day operation and implementation of the Departmental Compliance Plan within that Department.

6.) “Compliance” for purposes of this Corporate Compliance Plan, shall refer to all of the County’s activities that provide oversight, guidance and accountability for its governing officials, employees and contractors to assure that its business practices pertaining to medical reimbursements and payments conform with the standards required by state and federal laws, rules and regulations, as well as the County’s policies and procedures.

7.) “Abuse” means practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs to the medical assistance program, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care.

8.) “Fraud” for purposes of this Corporate Compliance Plan means:

   a. an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person; or
   b. the act(s) of any person who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids or abets any person to obtain medical assistance to which he or shee is not entitled; or
   c. the act(s) of any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise; or
   d. retaining a benefit after the person becomes aware that the benefit is not authorized under federal or state guidelines.

C. *The Plan's Fundamental Components*.

The County Corporate Compliance Plan consists of eight (8) elements. They are as follows:

1.) Written compliance policies and procedures that describes the County's Compliance Plan, including a Code of Conduct;
2.) Appointment of a Compliance Officer who is responsible for the day-to-day operation of the Corporate Compliance Plan and a Compliance Committee to assist the Compliance Officer;
3.) Training and education of all affected Covered Person on the Compliance Plan;
4.) Mechanisms to report compliance concerns;
5.) Disciplinary policies to encourage good faith participation in the Compliance Plan;
6.) System for identifying compliance risk areas, including monitoring and auditing;
7.) System for responding to, investigating, and correcting compliance issues; and
8.) A policy of non-intimidation and non-retaliation for good faith participation in the Plan.

Cayuga County's development and implementation of these eight (8) elements will require the full cooperation and participation of all Covered Person. Such cooperation and participation will ensure that the County maintains a high level of honest and ethical behavior in the delivery of its services.

II. <u>Code of Conduct</u>.

It is the County's policy that all Covered Person shall comply with all laws, regulations, and ethical standards applicable to their duties. In addition, Covered Person are required to follow the County's policies regarding employee conduct as well as the County's Code of Ethics. While each Covered Department has its own rules and regulations that govern its specific operations, there are general standards of conduct applicable to this Compliance Plan. The following standards of conduct apply:

A. *General Standards*.

<u>Honesty and Lawful Conduct</u>. Covered Person must be honest and truthful in all of their dealings. Covered Person must avoid doing anything that is, or might be, against the law. If you are unsure whether an action is lawful, then you should not do it until you have checked with your supervisor or the Compliance Officer.

<u>Respect for Patients/Clients Served</u>. Covered Person must fully respect the rights of the patient/clients (collectively referred to as "Individuals") served including their right to privacy, respect, dignified existence, self-determination, participation in their own care and treatment,

freedom of choice, ability to voice grievances, and reasonable accommodation of Individual needs.

Confidentiality. Covered Person must hold the information concerning the Individuals they serve in the strictest of confidence. Such information will not be disclosed to anyone unless authorized by the Individual or his/her representative or otherwise permitted or required by law. It is the County's policy to comply with all applicable confidentiality laws, including HIPAA, the New York State Mental Hygiene Law, the HITECH Act, Family Educational Rights and Privacy Act ("FERPA") and the Red Flag Identity Theft rules. Covered Person are referred to the County's HIPAA Policy for more detailed information describing their duties and responsibilities in this regard.

Business Information. Covered Person may not disclose or release any confidential information relating to the County's operations, pending or contemplated business transactions, trade secrets, and confidential Covered Person information without the prior authorization of the appropriate supervisor or Department Head. All confidential information is to be used for the benefit of the County and the Individuals it serves and is not to be used for the personal benefit of Covered Person, their families, or friends. Covered Person are referred to the Cayuga County Ethics Code for a more detailed description of their duties and responsibilities in this regard.

- Employees who violate the provisions of this Plan may be subject to disciplinary action up to and including termination.

B. *Billing for Services.*

Accurate and Truthful Claims and Cost Reports. Claims submitted for payment must be accurate, truthful and reflect only those services and supplies which were ordered and provided. Cost reports must be prepared as accurately as possible and adequate documentation must exist to support information provided in the report. Non-allowable costs must be appropriately identified and removed, and related party transactions must be treated consistent with applicable laws and regulations.

Coding. Coding of services shall accurately reflect the services rendered.

Verification of Coverage. To the best of Covered Person's ability, insurance coverage and benefits shall be verified. Any changes in coverage, or changes in benefits, shall be promptly communicated to the Individual and their family in writing. Covered Person shall comply with the requirement that Medicaid or Medicare is a payor of last resort and shall ascertain that other payors are not primary before billing Medicaid or Medicare.

<u>Adequate Documentation</u>. 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 payor requirements.

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

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

C. *Payment*.

<u>Refunds/Credit Balances</u>. If a Covered Department becomes aware of payments for which it was not entitled from a governmental or private payor or a recipient, the payments shall be refunded to the appropriate payor or recipient.

<u>Receipt of Payments and Gifts</u>. Consistent with the County's Code of Ethics, Covered Person may not accept any gifts, gratuities, or tips from any individual or entity, such as contractors or vendors, that are intended, or could be interpreted as intending, to influence the staff member's actions and decisions.

<u>Payment of Items or Gifts</u>. Consistent with the County's Code of Ethics, Covered Person 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.

<u>Exception for Nominal Value</u>. Covered Person 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 of the recipient. "Nominal value" is defined as $25.00 or less.

D. *Medical Necessity and Quality of Care and Services*.

<u>Delivery of Care and Services</u>. All Individuals who receive medical treatment from the County shall be afforded the care and services reasonably necessary to attain or maintain the highest possible physical, mental, and psycho-social well-being.

Ability to Provide. The County shall make a good faith effort to refer Individuals and their families to other appropriate providers when it cannot provide for the Individual's identified needs.

Medical and/or Educational Necessity. Medical care and services shall be based on medical necessity and professionally recognized standards of care.

Quality Assurance. Covered Departments shall have processes in place to objectively measure and systematically monitor the quality and appropriateness of medical care and related services; as well as to identify and pursue opportunities for improvement. To the extent possible, the County's quality assessment and improvement processes shall be coordinated with the County's Corporate Compliance Plan.

E. *Governance.*

Board Oversight. Cayuga County's Board of Health and the Cayuga County Legislature shall exercise reasonable oversight over the implementation of the Corporate Compliance Plan and ensure that they receive relevant information in a timely manner as is necessary and appropriate. The duty of "reasonable oversight" includes the duty to make reasonable inquiry when presented with extraordinary facts or circumstances of a material nature (i.e. indications of financial improprieties, self-dealing, or fraud) or a major governmental investigation.

Conflict of Interest. In accordance with Cayuga County's Code of Ethics, any actual or potential conflict of interest must be disclosed to ensure the integrity of the County's operations. All Covered Person 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 County in any manner.

F. *Credentialing.*

Background Checks. The County, through the Cayuga County Human Resources Department, shall screen prospective employees, members, and contractors prior to engaging their services against websites which provide information on excluded individuals and entities, criminal backgrounds, and professional licensure and certification. Screening should be done periodically to ensure such individuals and entities have not been excluded, convicted of a disqualifying

criminal offense, or had their licensure or certification suspended, revoked or terminated since the initial screening.

Notice to Contractors. All County contracts shall contain a notice that the County's Compliance Plan applies to all transactions, including without limitation, notice that if the contractor has been convicted of an offense that would preclude employment under Medicaid or Medicare regulations, the contractual relationship shall be subject to termination.

G. *Business Practices*.

The County is committed to complying with all federal, State and local laws, rules and regulations in its business practices. Further, the County has adopted a Code of Ethics (Local Law No. 5 – 2021) to govern the expectations of ethical conduct by its elected officials and employees.

Stark Law and Anti-Kickback Statute. As more fully described in Exhibit A, the Stark Law prohibits any physician or other health care provider employed by or contracting with the County from making a referral for health care services to any entity with which the physician or any members of his/her immediate family has a financial relationship. The Anti-Kickback Statute prohibits the County or any of its employees or contractors from, soliciting, offering or receiving anything of value in exchange for referring goods or services which are paid for through Medicare or Medicaid. Both the recipient and the offeror of the remuneration are subject to the Anti-Kickback Statute. The County will promptly review and investigate any instance of alleged violation of these statutes.

Business Records. Business records must be accurate and truthful, with no material omissions.

Relationships with Other Providers. Contracts, leases, and other financial relationships with hospitals, physicians, hospices, other medical providers and suppliers who have a referral relationship with the County shall be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties. Free or discounted services or items will not be accepted or provided in return for referrals.

III. Compliance Officer.

A. *Authority and Duties*.

Cayuga County has appointed the Operations Officer to be the Corporate Compliance Officer for this Compliance Plan as well as the Cayuga County HIPAA Policies. Each Covered Department shall appoint a compliance officer to run the day-to-day operations of the Compliance Plan in their respective Covered Departments and are responsible for receiving, investigating, and responding to all reports, complaints, and questions about compliance issues in collaboration with the County Compliance Officer and the County Attorneys.

The Compliance Officer shall, with assistance of (but not limited to) the County Attorneys:

- Develop and implement policies, procedures, and practices designed to ensure compliance with the Corporate Compliance Plan and applicable laws and regulations.
- Develop and coordinate relevant educational and training Plans and materials;
- Conduct and facilitate internal audits to evaluate compliance and assess internal controls;
- Investigate compliance inquiries and Hotline complaints and if appropriate develop corrective action plans, including self-disclosure if appropriate;
- Ensure that the Human Resources Department is screening prospective Covered Person in accordance with this Plan;
- Ensure that physicians, independent contractors, suppliers, and other agents who furnish medical, nursing, or other healthcare or personal care services to the County are aware of the Plan's requirements;
- Work with the Compliance Committee, Cayuga County Board of Health, and Cayuga County Legislature, in reviewing and modifying this Plan, to reflect the evolving nature of applicable laws and regulations and the priorities of the County;
- Coordinate and oversee the: (1) compliance initiatives of the County's Covered Departments; and (2) audits and investigations conducted by outside government agencies; and
- Maintain documentation of the following: internal and external audit and investigation results, logs of hotline calls and their resolution, corrective action plans, due diligence efforts with regard to business transactions, records of compliance training, and modification and distribution of policies and procedures.

The Compliance Officer's scope of authority and duties shall be determined by the Cayuga County Legislature and may be modified from time to time as the Compliance Plan is evaluated.

B. *Reporting Responsibility*.

Investigative Reports. Compliance issues shall be reported to the relevant Covered Department's compliance officers, who in turn shall report to the County's Corporate Compliance Officer. The Corporate Compliance Officer, together with the County Attorney's Office, shall initiate an investigation into the complaint. Upon completion of the investigation, the Corporate Compliance Officer shall work with the affected Covered Department's compliance officers and Department Head to initiate a corrective action plan. Reports of the Corporate Compliance Officer's investigation shall be provided to the Cayuga County Chairperson and the Department Head of the affected Covered Department.

Annual Reports. The Corporate Compliance Officer shall report at least annually to the Cayuga County Legislature, and the County Board of Health regarding the activities of the Compliance Committee.

Internal Reports. The compliance officers for each of the Covered Departments shall regularly report directly to the Corporate Compliance Officer on the activities of their respective Compliance Plans.

IV. Compliance Committee.

A. *Appointment*.

The Chair of the Cayuga County Legislature shall appoint a Compliance Committee to work with the Corporate Compliance Officer and assist in the implementation of the Compliance Plan. The Committee shall, at a minimum, include the Corporate Compliance Officer, the compliance officers for each of the Covered Departments, and the County Attorney, Additional members may be included depending on the scope of any issue reported. Additional members may include other members of senior management, including representatives from departments such as finance and human resources. The Corporate Compliance Officer shall be the chairperson for the Committee and the Committee shall support the Corporate Compliance Officer in fulfilling their responsibilities. The Compliance Committee shall assist the Compliance Officer with the report to the Cayuga County Legislature.

B. *Duties*.

The scope of the Committee's duties and responsibilities shall be determined by the Chair of Legislature and may be modified from time to time as the Compliance Plan is evaluated. The Committee's primary duties are:

- Identification of specific risks areas,

- Assessing existing policies and procedures that address these risk areas and modifying them as needed,
- Working with departments to develop or modify standards of conduct, policies and procedures to promote compliance with legal and ethical requirements,
- Developing and evaluating appropriate strategies to promote compliance with the Compliance Plan and detection of any potential violations,
- Evaluation and approval of all Covered Departments' Compliance Plan initiatives, processes and documentation, and
- Receiving, reviewing, and recommending appropriate responses to reports of actual or potential non-compliance with applicable laws, regulations, Code of Conduct, and policies and procedures in coordination with the Compliance Officer and with the assistance of counsel as necessary.

C. *Meetings.*

The Committee shall meet at a minimum of twice a year (or more often as necessary) to review the Compliance Plan and compliance activities.

V. <u>Compliance Training and Education</u>.

A. *Applicability.*

All Covered Person within each of the Covered Departments shall participate in training and education on the Compliance Plan including the Code of Conduct. Training Plans should include sessions reviewing the County Corporate Compliance Plan, the County HIPAA Policies, the Covered Department's departmental compliance/HIPAA procedures and a summary of the fraud and abuse laws and federal health care Plan and private payor requirements.

C. *Frequency*.

Such training shall occur initially upon hire as part of the orientation for new employees provided by Human Resources Department with refresher courses to occur at least annually thereafter. Training shall also be provided to the members of the Cayuga County Board of Health and Cayuga County Legislature. Such training is mandatory. Failure to participate may result in disciplinary action which may consist of a written warning up to and including possible termination subject to the due process, legal and contractual rights, if any, applicable to such individual.

D. *Records of Training*.

The compliance officers for the Covered Departments shall ensure that records are maintained, including copies of training materials, the types of training Plan offered, dates offered, and the individuals in attendance for a period of ten (10) years from the date of training. Copies of the training records shall be forwarded to the Corporate Compliance Officer.

E. *Periodic Review of Training*.

The County Compliance Officer and Compliance Committee shall monitor, evaluate and assess the effectiveness of the Covered Department's training and education programs and revise as necessary at least once each calendar year.

F. *Distribution of Compliance Information*.

In addition to periodic training and in-service Plans, the compliance officers for each of the Covered Departments shall communicate any relevant new compliance information.

G. *Distribution of Plan*.

This Corporate Compliance Plan shall be distributed to all Covered Person in whatever format is deemed appropriate. Covered Person shall be required to certify their review and receipt.

VI. Reporting Compliance Issues.

A. *Required Reporting*.

If a Covered Person believes that fraud, waste, abuse or other improper conduct has occurred, the individual is required to report such information. 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 reports to the extent feasible and permitted by law.

An individual may report a concern to:

Their supervisor(s);
Their Department Head;
The County's Corporate Compliance Officer;
Cayuga County Board of Health and/or Cayuga County Legislature;
The County's Compliance Hotline. The dedicated Compliance Hotline number is 315-294-8015. Calls to the Hotline may remain anonymous.

In Writing. Complaints or reports may be made anonymously via written letter sent directly to the County's Corporate Compliance Officer.
OIG's Compliance Hotline. Covered Person may contact the Office of Inspector General hotline at 1-800-447-8477 for Medicare related issues.

B. *Confidentiality*.

Any individual who reports a compliance concern in good faith shall have the right to do so anonymously. 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.

C. *Non-Retaliation and Non-Intimidation*.

Any individual who reports a compliance concern in good faith shall be protected against retaliation and intimidation. In such an instance, retaliation is itself a violation of the Code of Conduct and unlawful, and will not be tolerated. However, if the individual who reports the compliance issue has participated in a violation of law, the Code of Conduct or the County's policy, the County retains the right to take appropriate disciplinary or other action against them, up to and including termination of employment or service.

VII. Responding to Compliance Complaints.

A. *Investigation of Reports*.

Upon receiving a credible report of suspected or actual fraud, waste, abuse or other improper conduct, the Compliance Officer shall investigate such report through internal compliance processes, as well as the County Attorney's Office, the applicable Covered Department Head, and other experts to assist as appropriate and necessary. The County requires that all Covered Person 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, the documents reviewed, the results of the investigation, and any disciplinary and/or corrective action plan.

B. *Corrective Action*.

After appropriate investigation, the Compliance Officer in collaboration with the County Attorney's Office, the Covered Department Head, and the Chair of the Legislature, shall institute corrective action as deemed necessary and maintain documents of same.

C. *Disciplinary Action*.

After appropriate investigation, if the Compliance Officer determines that a County employee or contractor may be responsible for violating this Plan, County policies, and/or federal or state regulations, the Compliance Officer shall refer such findings to the County Attorney's Office, for the purpose of initiating appropriate sanctions. Sanctions to be imposed may include monetary penalties, suspension, or termination. Sanctions shall be imposed subject to the due process requirements of state or federal law and applicable collective bargaining or employment contracts.

- Employee sanctions can range from an oral warning up to and including termination.
- Board of Health or Legislative member sanctions can range from written admonition up to and including, removal from office, in accordance with applicable bylaws, laws and regulations.
- Contractor sanctions shall range from written admonition, financial penalties, up to and including, termination of the contract.

VIII. Monitoring and Auditing.

A. *System for Identifying Risks.*

The Compliance Officer in collaboration with Compliance Committee members shall develop a system for routine identification and evaluation of compliance risk areas. Such a monitoring and auditing system shall include the performance of regular, periodic compliance audits by internal or external auditors and department heads or designated Covered Person(s). Such audits will include reviews of the business and billing practices of the County and include measures to identify, anticipate, and respond to billing and payment risk areas. In addition, such System shall include a periodic review of the Corporate Compliance Plan to determine the continued effectiveness of the Plan.

B. *Corrective Action Plans*.

The Compliance Officer shall receive and review the results of such internal reviews, work in collaboration with the Compliance Committee members and Covered Department Heads to develop a corrective action plan to remedy any deficiencies identified in the results. The Covered Department Heads shall be responsible for implementing such corrective actions and reporting the results to the Compliance Committee. Where additional investigation of such deviations is appropriate, the Compliance Officer and/or in consultation with the Committee, shall retain the services of independent advisors as may be necessary.

Adopted: Res. No. 499-2010
Revised: Res. No. 117-2019
Revised: Res. No. ___-2023

C. *Government Inquiries*.

If contacted by an outside government official, all Covered Persons are required to obtain the official's identification and immediately inform their Department Head (or designee) of the contact. To the extent that such government contact involves an actual or potential compliance issue, the Department Head (or designee) shall notify the County's Corporate Compliance Officer and if necessary, the County Attorney before they speak to such officials. The Department Head, the County Legislative Chairperson and/or the Compliance Officer shall attempt to obtain additional information from the government official which will be useful to the County in deciding how to respond to the official's request.

In no event, however, shall any Covered Person respond to a request to disclose the County's documents without first speaking with their Department Head and/or Compliance Officer and receiving their approval to release documents. The Department Head and/or Compliance Officer shall seek advice from the County Attorney prior to the release of any documents or records to any outside government agency.

IX. Compliance Contacts and Numbers.

Any Covered Person may contact their Department Head (or designee) the Departmental Compliance Officers, the County Compliance Officer or the County's Compliance Hotline with any compliance question or concern.

The contact information is as follows:

Cayuga County Corporate Compliance Officer. The Corporate Compliance can be reached at 315-294-8015. Callers may remain anonymous.

OIG's Compliance Hotline. Employees/contractors may contact the Office of Inspector General hotline at 1-800-447-8477 or the Office of Medicaid Inspector General Fraud Hotline at 1-877-873-7283.

X. Laws Regarding the Prevention of Fraud, Waste and Abuse.

All Covered Persons should be aware of both federal and State laws pertaining to the prevention of fraud, waste and abuse. These laws address potential criminal and civil penalties that may be imposed personally upon a Covered Person who violates these provisions and may

Adopted: Res. No. 499-2010
Revised: Res. No. 117-2019
Revised: Res. No. ___-2023

result in civil fines and penalties against the County. A summary of applicable laws appears as Exhibit A annexed hereto.

XI. Whistleblower Protections.

It is the policy of Cayuga County that no County employee shall be subjected to intimidation or retaliation as a result of their good faith participation in the County's Compliance Plan. Therefore, it is further the policy of Cayuga County to prohibit any County employee, department head, manager or supervisor, or any elected official from engaging in or threatening to engage in "retaliatory personnel action" against any other County employee or other Covered Person for good faith participation in this Corporate Compliance Plan.

Good faith participation in the program may include but is not limited to:

- Reporting of potential compliance issues;
- Investigating or participating in the investigation of compliance issues, including testifying before any public body or officer investigating, inquiry or hearing into any such compliance issue;
- Participating in self-evaluations;
- Participating or cooperating with internal or external audits;
- Objecting to, or refusing to participate in any activity, policy or practice that the employee reasonably believes in good faith to be in violation of a law, rule or regulation;
- Participating in or facilitating remedial actions; and
- Reporting to any federal, state, or local regulatory, administrative, or public agency or authority, or instrumentality thereof, including any federal, state, or local law enforcement agency, prosecutorial office, or police or peace officer any activity which the employee reasonably believes in good faith to be a violation of any federal or state law, rule or regulation.

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

A more particular description of the pertinent portions of state and federal laws describing these "whistleblower" protections is annexed as Exhibit A.

Adopted: Res. No. 499-2010
Revised: Res. No. 117-2019
Revised: Res. No. ___-2023

XII. PLAN ANNUAL REVIEW

The Corporate Compliance Officer shall oversee together with the Compliance Committee an annual review of the Corporate Compliance Plan. The Corporate Compliance Officer shall review the procedures outlined for each Covered Department to ensure that staff understand and have a working knowledge of same. The Corporate Compliance Officer shall report annually to the Cayuga County Board of Health and Cayuga County Legislature on the activities and the effectiveness of the Plan. In addition, the Corporate Compliance Officer shall ensure that all Covered Departments certifications of compliance required by law to be filed with government regulatory agencies are filed in a timely fashion.

XII. SUMMARY

Cayuga County's Corporate Compliance Plan provides an administrative framework for addressing the areas most likely to present a compliance risk. In addition, the Compliance Plan establishes specific policies and procedures to assure that the County and its Covered Departments are compliant with all federal and state laws, rules and regulations.

Cayuga County requires all Covered Persons to sign an acknowledgment confirming they have received the Compliance Plan and the Code of Conduct, understand it represents mandatory policies of Cayuga County and agree to abide by it. All employees are required to sign this acknowledgment as a condition of employment.

Adopted: Res. No. 499-2010
Revised: Res. No. 117-2019
Revised: Res. No. ___-2023

Exhibit A
FEDERAL & NEW YORK STATUTES RELATING TO FALSE CLAIMS

I. FEDERAL LAWS

False Claims Act (31 USC §3729-3733)

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

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; … or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
>
> ***
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus three (3) times the amount of damages which the Government sustains because of the act of that person...
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. 31 U.S.C. § 3729.
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> ***

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

Adopted: Res. No. 499-2010
Revised: Res. No. 117-2019
Revised: Res. No. ___-2023

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

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

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

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

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

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

II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. *CIVIL AND ADMINISTRATIVE LAWS*

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

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

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

Social Services Law §145(b) - False Statements

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

Social Services Law §145(c) – Sanctions

If any person applies for or receives public assistance, including Medicaid, by

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

B. CRIMINAL LAWS

Social Services Law §145 - Penalties

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

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

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

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

Penal Law Article 155 – Larceny

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

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

a Class B felony.

Penal Law Article 175 - False Written Statements

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

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

Penal Law Article 176 - Insurance Fraud

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

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

once. It is a Class D felony.

Penal Law Article 177 - Health Care Fraud

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

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

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

III. WHISTLEBLOWER PROTECTION

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

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

NY False Claim Act - State Finance Law §191

The False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority *as* the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back

pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law §740

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

New York Labor Law §741

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

IV. ANTI-KICKBACK STATUTES

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

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

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

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

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

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

vary with volume or value.

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

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

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

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

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

- free or significantly discounted office space, equipment or staff;
- free training for physician's office staff;
- discounted loans or loan forgiveness tied to patient referrals;
- conference and/or continuing education expense reimbursement;
- insurance coverage at a below-standard cost;
- payment for services requiring few actual duties;
- a discounted price or a gift, coupon, bonus or cash payment to physicians

in exchange for or based on prescribing or ordering specific products;

- cash or other benefits in exchange for performing sales-oriented, educational or patient outreach marketing; and in-office technicians, computers and/or fax machines at no charge, unless it can be shown that the staff or equipment is integral to the service being provided by the supplier, and limits are placed and monitored to assure staff and equipment are used by physicians only for the purposes of using or ordering the supplier's product.

V. **FEDERAL STARK LAW. 42 USC §1395nn.**

The Stark Law is a federal statute that prohibits physicians from referring patients to any entity for certain "designated health services" where the physician has an ownership interest or a compensation arrangement with that entity. In addition, the receiving entity is prohibited from submitting a claim or receiving payment for services provided pursuant to a prohibited referral. Because a "compensation arrangement" is defined as one which involves any form of remuneration, direct and indirect, the Stark Law will apply to every financial relationship between an entity and a physician, and likely such intermediaries and Internet based service providers who facilitate transactions between the physician and the provider of designated health services. "Designated health services" include outpatient prescriptions and radiology services.

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

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