# GENESEE COUNTY

## Corporate Compliance Program

11/2007
Rev-2008
Rev-2009
Rev-2010
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Rev-2012
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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 Corporate 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.

Our intent is to reasonably design, implement and enforce a Corporate Compliance Program that will disclose, prevent, and detect misconduct. All staff, agents, and independent contractors are expected to understand and adhere to this compliance program.

## II. CODE OF CONDUCT

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

**Billing**: Claims are only submitted for services that the organization has reason to believe are reasonable and medically necessary. Documentation to support billing claims will be maintained for seven years.

**Bribes, Gifts and Gratuities**: No person associated with the organization shall 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.**

**Cash and Bank Accounts**: No person with access to cash and bank accounts shall steal or otherwise misappropriate funds of the organization. All internal control procedures shall be adhered to at all times.

**Competition (Antitrust)**: The organization shall not participate in any venture with other organization(s) that collaborate on information and/or services intended to eliminate fair competition or to engage in price fixing in direct violation of antitrust laws.

**Confidential Information**: All persons associated with the organization shall 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.

**Conflict of Interest**: All persons associated with the organization shall disclose any potential conflict of interest and refrain from any activity that represents an unfair business advantage by virtue of their business interest or employment with **Genesee**

**County as long as it does not affect the employee's performance at Genesee County or represent a conflict of interest.**

**Contributions**: No person associated with the organization shall use force or coercion over another person to solicit contributions.

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

**Financing/Loan Agreements**: The organization 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.

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

**Non-Discrimination**: All persons associated with the organization shall adhere to state and federal laws prohibiting discrimination because of age, race, gender, color, marital status, disability, sexual preference or national origin while conducting business activity of the organization.

**Resident Rights**: All persons associated with the organization shall adhere to the standards of conduct defined in the facility's Bill of Resident Rights.

**Research Grants**: All individuals associated with an organizational-sponsored Research Grant shall conduct their activity in accordance with the grant guidelines. All grant funds shall be used only in accordance with the grant approval with documentation to support all grant activity.

**Tax Exemption**: The organization shall not engage in any prohibited activity that violates, or could result in a challenge of, its tax exemption status.

## III. OVERSIGHT RESPONSIBILITY

a. The responsibility of overseeing the Genesee County Corporate Compliance Program will be with the **Genesee County Corporate Compliance Officer reporting to the Genesee County Corporate Compliance Committee & Genesee County Manger's Office. The Genesee County Corporate Compliance Committee is overseen by the Chair of the Genesee County Legislative Health & Human Services Committee.**

b. The duties and responsibilities of the **Compliance Officer** shall be as follows:

1. Oversee that the organization takes steps to effectively communicate its code compliance and program procedures to all affected staff and agents.

2. Oversee that the organization takes reasonable steps to achieve compliance with its standards by utilizing monitoring and auditing systems reasonably designed to detect misconduct by its employees and agents.

3. Follow-through on any detected or reported incidents of possible misconduct under the direction and supervision of legal counsel.

4. Report any and all compliance activity to the **Corporate Compliance Committee quarterly and the Health & Human Services Committee semiannually. The Health& Human Services Committee** will report to the County Legislators annually **or as needed.**

5. Delegate appropriate levels of monitoring and review of systems to other staff and outside agencies to promote effectiveness, efficiency, and to avoid any potential conflicts of interest.

c. **The Corporate Compliance Officer may seek outside legal counsel to render legal opinions; advise the Compliance Committee on developments and changes in laws, regulations and policies that affect the compliance program;** review and approve the compliance program and any revisions; and advise on any enforcement or discipline pertaining to reports of misconduct.

## IV. COMMUNICATION AND TRAINING

**a. All billing, clerical & clinical staff will have a training session, with an objective to ensure that all participants understand and appreciate all aspects of the Compliance Program, including the risks of non-compliance. Training will also include Management staff and Board Members.**

b. <u>All staff and agents shall receive a publication explaining the Compliance Program, including notification of how and where they can receive more extensive information and details on the program</u>

c. <u>Publication of the Compliance Program shall be included in all new employees' orientation training packets and included with all new agent contracts.</u>

d. <u>A Compliance Program poster shall be posted on a bulletin board to assist communication of policy and procedures of the program, as well as the Compliance Hotline number for reporting concerns and misconduct.</u>

e. <u>Annual review of the Compliance Program shall be included in the facility's mandatory inservices for all staff.</u>

## V. MONITORING, AUDITING AND EXCLUSION PROCEDURES

a. All staff and agents shall be aware of the Code of Conduct expectations of the Compliance Program and report any suspected violation to reasonably ensure that all activities are in compliance with the organization's standards and procedures.

b. The organization shall have an annual financial audit conducted by its certified public accountants to examine evidence supporting the proper handling and reporting of amounts and disclosures relating to financial activity of the organization.

c. The organization shall conduct annual reviews and business and contractual agreement relationships to reasonably ensure that activities are in compliance with the organization's standards and procedures.

d. The organization shall maintain a disclosure listing of all individuals associated with the organization who have identified outside party interests that represent potential conflicts of interest.

e. The organization shall conduct an annual review of compliance with regards to the terms, conditions, and covenants contained in the organization's financing/ loan agreements.

f. The organization shall conduct an annual review of its billing practices to reasonably ensure that all activities are in compliance with the organization's standards and procedures. These reviews will alternate between internal audits and audits completed by outside financial accounting firms. Audit results will be communicated to the Corporate Compliance Committee for appropriate action. Audit results will also be communicated to the Human Services Committee for their review and action.

**g. The organization shall conduct exclusion exercises in an effort to determine current or prior fraud from all involved staff.**

## VI. REPORTING AND RESPONSE SYSTEM

All employees and agents of the organization have a duty to report suspected misconduct, anonymously if they choose, and without any fear of retaliation or breach of confidentiality.

1. Individuals may approach the **Compliance Officer** directly to report suspected misconduct.

2. Individuals may submit, in writing, reports of suspected misconduct to the **Compliance Officer.**

3. Individuals may also call the Compliance Hotline (anonymous) to report concerns and suspected misconduct. The Compliance Hotline number is

   **Local: 585-344-4007 or 1-866-619-4039**
   **New York State: 1-844-823-2262**

The Compliance Officer shall initially conduct a preliminary review of the report and may direct any concerns to legal counsel for opinions, advice and direction on any further investigation, enforcement or discipline.

Reports of misconduct that do not warrant further investigation or review with legal counsel shall be clearly documented as to why no further investigation was undertaken.

The Compliance Committee shall oversee any need to make policy and procedure modifications with respect to correcting and preventing further misconduct of a similar type as a result of a misconduct investigation.

The following are the telephone numbers and extensions in the Genesee County Corporate Compliance Program.

**Corporate Compliance Officer**
Matt Landers, Asst. County Manager (585) 344-2550 ext. 2295

**Genesee County Legislator**
**Rochelle Stein** **(585) 344-2550 ext. 2202**

**County Manager's Office**
**Jay Gsell** **(585) 344-2550 ext. 2204**

## VII. ENFORCEMENT AND DISCIPLINE

The Compliance Program's Code of Conduct, as well as Genesee County Corporate Compliance disciplinary guidelines shall be consistently enforced through appropriate disciplinary mechanisms, subject to Federal, State & Local Medicaid laws and Genesee County's personnel policies.

1. Disciplinary procedures for abuse of the County's Corporate Compliance Program will follow the guidelines under Federal, State & Local Medicaid laws and existing personnel policies and may result in immediate discharge. These disciplinary procedures apply to all employees of the Genesee County.

2. Grievance procedures for opportunities to respond to allegations or evidence of misconduct will follow the guidelines under existing Federal, State & Local Medicaid laws, County personnel policies and its collective bargaining agreements.

3. Disciplinary measures that are appropriate shall be determined on a case-by-case basis and will involve the advice of legal counsel.

4. Disciplinary measures and procedures may involve consideration and direction from outside third-parties (e.g., governmental policy, law enforcement agencies), including fines, reimbursement of funds and criminal prosecution.

## VIII CONFLICT OF INTEREST POLICY

Section 1. Purpose

To protect Genesee County's interest when contemplating whether or not to enter into transaction or arrangement that might benefit the private interest of an Officer or Director of Genesee County. This policy is intended to supplement but not replace any applicable state laws or regulations governing conflicts of interest.

Section 2. Definitions

A. Interested Persons

Any Director, principal officer, or member of a committee with Genesee County delegated powers that have a direct or indirect interest with Genesee County Mental and or Genesee County Public Health, as defined below.

B. Financial Interest

A person has a financial interest either directly or indirectly, through business, investment or family;

1. An ownership or investment interest in any entity with which Genesee County Mental or Public Health has a transaction or arrangement.
2. A compensation arrangement with Genesee County Mental Health and or Genesee County Public Health or with any entity or individual with which Genesee County Mental Health and or Genesee County Public Health has a transaction or arrangement; or
3. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which Genesee County Mental or Public Health is negotiating a transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature. A financial interest is not necessarily a conflict of interest. A person who has a financial interest may have a conflict of interest only if the appropriate Board or committee decides that a conflict or interest exists.

Section 3. Procedures

A. Duty to Disclose

In connection with any actual or possible conflicts of interest, an interested person must disclose the existence of his or her financial interest and all material facts to County Legislators and members of committees with County delegated powers considering the proposed transaction or arrangement.

B. Determining Whether a Conflict of Interest Exists

After disclosure of the financial interest and all material facts, and after any discussion with the interested person, he or she shall leave the Ways and Means Committee meeting while the determination of a conflict is discussed and voted upon. The Ways and Means Committee members shall decide if a conflict of interest exists.

C. Procedures for Addressing the Conflict of Interest

1. The chairperson of the Ways and Means Committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.
2. After exercising due diligence, the Ways and Means Committee shall determine whether Genesee County Mental Health or Genesee County Public Health can obtain a more advantageous trans-action or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict of interest.
3. If a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the Ways and Means Committee shall determine, by a majority vote of the disinterested Directors, whether the transaction or arrangement is in Genesee County Mental Health or Genesee County Health Department's best interest for its own benefit and whether to enter into the transaction or arrangement in conformity with such determination.
4. An interested person may make a presentation to the Ways and Means Committee meeting, but after such presentation, he or she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement that result in the conflict of interest.

D. Violations of the Conflict of Interest Policy

1. If the Ways and Means Committee had reasonable cause to believe that an Officer, Director, or Legislator has failed to disclose actual or possible conflicts of interest, it shall inform the member of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose.
2. If, after hearing the response of the Officer, Director, or Legislator and making such further investigations as warranted in the circumstances, the Ways and Means Committee determines that the member has, in fact, failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

## IX FEDERAL AND STATE LAWS ON FALSE CLAIMS, FALSE STATEMENTS AND WHISTLEBLOWER PROTECTIONS

Several federal and state laws enable the government to impose administrative remedies, civil sanctions, and criminal penalties for false claims or false statements made in connection with federal health care programs, such as Medicare and Medicaid.

***Federal False Claims Act (31 U.S.C. §§ 3729 – 3733)***

The Federal False Claims Act allows the United States Attorney General or a private citizen to sue an individual or an entity for making certain "false claims" in connection with government business. A person makes a false claim if he or she:

- knowingly presents a false claim for payment or approval to a federal government officer or employee;
- knowingly makes or uses a false record or statement to get a false or fraudulent claim paid by the federal government;
- conspires to defraud the federal government by getting a false claim paid;
- has property or money used by the federal government and delivers less than the amount for which he or she gets a receipt, with the intent to defraud the federal government;
- gives a receipt to the federal government without completely knowing that the information on the receipt is true, with the intent to defraud;
- knowingly buys or receives a pledge of public property from a federal government officer or employee who cannot lawfully sell the property; or
- knowingly makes or uses a false statement to conceal, avoid, or decrease an obligation to pay money to the federal government.

A person can be found to have "knowingly" made a false statement if he or she acted in deliberate ignorance or reckless disregard of the truth of the statement.

A person who knowingly makes a false claim may be held liable to the federal government for a civil penalty of $5,000 to $10,000. He or she may also be liable for two to three times the amount of damages the federal government sustained. Whether the damages are doubled or tripled depends on whether the person cooperated with the government and other factors.

A suit for a false claim can be initiated by the United States Attorney General or by a private citizen who has independent knowledge of the facts. A private citizen wishing to bring a Federal False Claims Act suit can only do so within the following time limits, whichever occurs last:

- within six years after the false claim was made; or
- within three years after the government should have become aware of the false claim, but in no event more than ten years from when the violation was committed.

A private citizen who brings a false claims suit must do so in the name of the federal government. After the private citizen (the "relater") prepares a formal complaint and serves it on the government, along with all information that he or she has, the government may decide to take over the suit. If the government takes over the suit, it is not bound by the decisions of the relater, and the government can dismiss or settle the suit even if the relater objects. The relater may remain in the suit, or the court may limit the relater's participation.

If the government informs the court that it does not want to take over the suit, the private party can continue with the suit, if he or she is an original source of the information on which it is based. If the private party continues with the suit but does not prevail, the private party may have to pay the defendant's reasonable attorney's fees and expenses, if the court finds that the action was frivolous or was brought to harass the defendant.

If the government prosecutes the suit and prevails, the relater who brought the case to the government may receive 15% to 25% of the court award or settlement, depending on his or her contributions to the proceeding. The relater will also be awarded reasonable expenses and attorney's fees. However, if the suit was based primarily on information from another case, a government report or the news media, the relater may be awarded no more than 10% of the award or settlement.

If the government does not take over the action and the relater prevails, the relater will receive 25% - 30% of the court award or settlement plus his or her reasonable expenses and attorney's fees. Whether or not the government proceeds with the action, however, if the relater planned or initiated the false claim in the first place, he or she may recover nothing.

An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against because he or she brought or participated in a False Claims Act suit may be entitled to reinstatement, double back pay plus interest, and compensation for other damages that he or she proves. In order to seek such relief, the individual must bring a separate action in federal court.

***Federal Administrative Remedies for False Claims and Statements (31 U.S.C. §§ 3801 – 3812)***

In addition to a suit under the False Claims Act, the federal government (but not a private citizen) can seek administrative penalties against a person or entity for making false claims. An individual or entity may be subject to administrative penalties for making or submitting a claim that the person knows or has reason to know is:

- false or fraudulent;
- includes or is supported by a written statement that includes false information or omits certain material facts; or
- is for payment for property or services the person has not provided as claimed.

Any person making such a false claim may be required, after a hearing, to pay a maximum penalty of $5,000 per claim and an assessment of up to double the amount of the claim.

***Health Care Fraud (18 U.S.C. §§ 1347)***

It is illegal to knowingly and willfully execute or attempt to execute a scheme to either defraud a health care benefit program or to obtain money or property from a health care benefit program by means of false pretenses or representation. The penalty for such actions in connection with the delivery of, or payment for, health care items or services may be a fine or up to ten years imprisonment, or both. If the violation results in serious bodily injury, the penalty may be a fine or imprisonment if up to 20 years, or both; if the violation results in death, the person may be fined or imprisoned for any terms of years or for life.

***False Statements Relating to Health Care Matters (18 U.S.C. § 1035)***

In a matter involving a health care benefit program, it is illegal for any person to knowingly and willfully falsify, conceal, or cover up by a trick, scheme or device a material fact; make any materially false fictitious, or fraudulent statement or representation; or make or use a materially false document knowing that it contains materially false statements. The penalty may be a fine or imprisonment for up to five years, or both.

***Theft or Embezzlement in Connection with Health Care (18 U.S.C. § 669)***

It is illegal to knowingly and willfully embezzle, steal, convert, or intentionally misapply money or assets of a health care program. The penalty may be a fine or up to ten years imprisonment, or both.

***Mail and Wire Fraud (18 U.S.C. § 1341)***

It is illegal to engage in a scheme to defraud or to obtain money or property by means of false or fraudulent pretenses, representations, or promises by using the U.S. mail or a commercial interstate carrier. Penalties may be fines or imprisonment for up to 20 years, or both.

***Racketeer Influenced and Corrupt Organizations ("RICO")(18 U.S.C. §§ 1961 – 1968)***

The RICO law prohibits certain "racketeering activity," including mail fraud. It is illegal to invest the profits from a pattern of racketeering activity or collection of an unlawful debt in any business, which affects interstate or foreign commerce. The penalty is a fine or up to 20 years in prison (of life imprisonment, if that penalty applies to the underlying crime) or both. The defendant may also be ordered to forfeit property to the government. Any person whose business or property is injured by the violation of these provisions can seek to recover in court three times the amount of damages he or she sustained, plus reasonable attorneys' fees and expenses.

***Services New York State Law Regarding False Statements Relating to the Medicaid Pro- gram (Social Law § 145-b)***

Under New York State law, it is illegal for a person, firm, or corporation to knowingly obtain or attempt to obtain payment from public funds for social services, including medical services, by:

- making a false statement or representation;
- deliberately concealing a material fact; or
- a fraudulent scheme.

Any person or entity that obtains or attempts to obtain such payment may be ordered to pay damages of three times the amount that was overstated. If the false statement was non-monetary, the damages may be three times the amount of loss that the state or other governmental entity incurred. In addition, if a provider of medical services is required to refund a payment received from the state or local government, the repayment must be made with interest.

In addition to requiring repayment of improperly claimed funds, the Department of Health may impose a penalty of up to $2,000 per item or service, if the provider has been subject to another penalty within the prior five years; the maximum penalty is $7,500 per item or service. These penalties may be imposed for:

- failing to comply with the standards of the medical assistance program;
- failing to comply with generally accepted medical practices in a substantial number of cases; or
- gross and flagrant violation of generally accepted medical standards; if that person also receives payment for claims when the provider knew, or had reason to know, that:

  - the care, services or supplies ordered or provided were medically improper, unnecessary or in excess of the medical needs of the patient;
  - the care, services or supplies were not provided as claimed;
  - the person who ordered or prescribed the care which was medically improper, unnecessary or in excess of the medical needs of the patient was suspended or excluded from the medical assistance program; or
  - the services or supplies were never provided to the patient.

Under New York law, actions involving false claims are brought by government officials, not by private parties. In July 2006, the New York State Legislature passed a bill regarding Medicaid fraud. Unlike the federal False Claims Act, this law does not allow a private citizen to bring a false claim action.

***Unacceptable Practices in the Medicaid Program (18 NYCRR §§ 515.2 – 515.3)***

Under New York Medicaid provider regulations, false claims and false statements are unacceptable practices. Sanctions that the Department of Health may impose on a provider for unacceptable practices include censure, repayment, and exclusion from participation in the Medicaid program. Making a false claim means submitting, or inducing or seeking to induce another person to submit, a claim for:

- care, services or supplies that have not been furnished;
- care, services or supplies provided at a frequency or in an amount that is not medically necessary;
- an amount that exceeds established Medicaid rates; or
- amounts substantially in excess of the customary charges or costs to the general public.

Making a false statement means making, or inducing, or seeking to induce another person to make, a false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment or for use in determining the right to payment.

Concealing or failing to disclose an event that affects the right to payment, with the intention that a payment be made when authorized or in an amount greater than the amount due, is also an unacceptable practice in the Medicaid program.

***Criminal Prohibitions under New York Law***

In certain circumstances, a person who makes false statements may be charged criminally under New York law. Falsifying business records (Penal Law § 175.00 – 175.15), Tampering with Public Records (Penal Law §§ 175.20 – 175.25), and Offering a False Instrument for Filing (Penal Law §§ 175.30 – 175.35) may each be a misdemeanor or a felony, depending on the intent of the perpetrator. Penalties include fines or imprisonment, or both.

**Prohibitions under the Social Security Act (42 U.S.C. Section 1320a – 7b):**

***False Statements.*** This section provides criminal penalties for knowingly or willfully making false statements in connection with the provision of benefits. More specifically, the law prohibits:

- Knowingly or willfully making (or causing to be made) a false statement of material fact:
- In any application for any benefit or payment
- For use in determining rights to benefits or payments;
- Concealing or failing to disclose information affecting the initial or continuing right to receive benefits for oneself or on behalf of another with fraudulent intent to secure either an unauthorized benefit or payment or a benefit or payment in a greater amount than due;
- Knowingly or willfully using benefits received on behalf of another for any purpose other than for that person's benefit;
- Presenting (or causing to be presented) any claim for payment for a physician's services knowing that the individual providing the services was not a licensed physician;
- Knowingly or willfully making, causing to be made, inducing, or seeking to induce, a false statement or representation of material fact with regard to conditions or operations of an entity in connection with qualification as an eligible organization or disclosure requirements.

***Illegal Remuneration.*** The statue also prohibits payment schemes that involve the exchange of money for referrals. Illegal remuneration is construed in the statute quite broadly. The statute prohibits:

- Knowingly or willfully soliciting or receiving "any remuneration (including any kick-back, bribe, or rebate) directly or indirectly, overtly or covertly, in cash, or in "kind" in exchange for
- Referring an individual for any reimbursable item or service; or
- Either acquiring or recommending that another acquire any reimbursable item or service; or
- Knowingly or willfully offering or paying any remuneration to induce any person to refer, acquire, or recommend acquisition of any reimbursable service or item.

The statute does provide for five exceptions or situations that do not constitute illegal kickbacks:

- Discounts properly disclosed and reflected in costs claimed or charges made;
- Amounts paid by an employer to a bona fide employee;
- Amounts paid by a vendor of goods or services to a group-purchasing agent, if
- There is a written contract with each group member stating what the agent is to be paid;
- The agent's compensation is based on a fixed amount or percentage of goods sold; and
- The agent discloses to any Medicare provider (i.e. hospitals or skilled nursing facilities) what amount he receives from each vendor for purchases that the provider makes;
- Payments as identified in the "safe harbor" regulations; and
- Co-insurance waivers by publicly funded community health programs.

The statute additionally prohibits knowingly or willfully (1) overcharging for services; (2) seeking payments as a condition to patient admission or continued stay; and (3) repeatedly violating the terms of assignments and agreements.

Civil Provisions (2 U.S.C. S 1320a – 7a). In addition to the criminal penalties, there are also civil penalties for false or improper claims when the person submitting the claim knew, or should have known, the service was not provided as claimed, or the claim is false; or payments to induce physicians to reduce or limit services to patients eligible for benefits. While civil violations do not expose the Genesee County Mental Health or Genesee County Public Health to criminal prosecution, they can result in significant civil fines.

***Exclusion from Participation in Medicare and Medicaid.*** In addition to the fines and penalties that may be imposed for violations, Medicare and Medicaid may exclude a violator from future participation in the programs. No payments may be made to anyone for services rendered by an excluded party: the physician may not be compensated, and labs and provider may not be compensated for services provided based on referral from an excluded physician. An individual convicted of criminal offenses related to patient negligence or abuse or to delivery of any reimbursable item or service must be excluded. Other convictions or failures, ranging from violation of the anti-kickback criminal provisions to failure to provide underlying documentation to determine what benefits are due, may result in exclusion.

**Kickbacks and Illegal Remuneration**

It is important for all employees to be aware of what constitutes illegal remuneration and how broadly this portion of the statute is interpreted. The statue prohibits any arrangement in which a thing of value is offered to induce the referral of business of the nature that may be paid for under Medicare, Medicaid, or state health programs. The response of the other party is not relevant to whether a crime has been committed. For example, if an employee offers a physician a fee for referrals, that employee has

committed a crime without regard to whether the physician accepts or rejects the offer. However, if the physician accepts, he/she has committed a crime as well.

To meet these concerns, the Corporate Compliance Plan addresses two things. First, all contracts or other arrangements with physicians or other referral sources will be cleared with the Executive Director of Administrator and approved by the Genesee County Legislature. Second, audit procedures will be designed to discover possible illegal kick-back arrangements and documents related to referrals and payments.

***The Safe-Harbor Regulations.*** The safe-harbor regulations identify situations that do not violate the anti-kickback statute. These regulations, however, do not provide great relief from anti-kickback provisions. There are specific requirements connected with each situation. If these requirements are not met, one of three results is possible. First, the arrangement violates the anti-kickback provisions. Second, the arrangement does not violate the provision and therefore compliance with a safe-harbor was unnecessary, I.e. because it involves a contract with an individual not able to affect the flow of referrals. Third, in some cases where the parties have attempted to comply but were unsuccessful reasons beyond their control, sanctions may not be imposed at the same level. This third possibility is, however, unpredictable.

While several of the provisions related to the organization of joint ventures and their investors, others relate to the creation of service and sales contracts and other routine transactions. Several of the safe-harbor provisions are outlined below. Other safe-harbor provisions may be added in the future.

***Contracts.*** All contracts must be in writing, signed by the parties, specify the terms (i.e. the space or equipment to be leased or the services to be provided), and last, for a term of one year. Rent or payments must be set in advance and be consistent with fair market value, and must not be tied to referrals. If the arrangement is part-time, the time periods involved and the charge per time period must be specified. The services provided under a service contract must not include any services that would violate the anti-kickback statute.

***Warranties and Discounts.*** Other arrangements that may be structure to fall within the safe harbors include warranties and discounts. Both the seller and the buyer must report reduced charges or free items based on warranties and the seller must inform the buyer of the reporting obligations. Payments related to other expenses arising from a defective product must be made only to the patient, not to the physician or facility. Manufacturer agreements to replace a competitor's product based on the competitor's warranty are protected.

Discounts may fall within the safe-harbor if properly structured. For example, rebate checks, credits, or coupons redeemable by the seller are protected. Cash payment; free or reduced charge goods provided for purchasing a different good or service; reductions applicable to some payors, but not to Medicare or state health programs; routine waivers of co-insurance and deductibles are all excluded. Discounts may be made only at the time of the original sale and must be reported on any benefit claim. Buyers who receive discounts also have requirements with which they must comply.

Basically, the buyer must:
Account for all discounts, on a fiscal year basis. Sellers must report all discounts on the invoice.

***Employment.*** Payments to bona fide employees are exempted if the Internal Revenue Services rules for Form W-2 are met.

***Review and Audit.*** Again, because the structure of the arrangement, such as duration or form of payment or purchase incentives, will determine whether the arrangement violates the anti-kickback rules, it is important that arrangement be cleared through the Compliance Officer and employees be instructed not to alter the terms of any approved arrangement. All contracts must be retained and audit procedures implemented.

***Billing Practices.*** There are a number of areas associated with billing practices that may expose a provider to allegations of fraud and abuse. The most important ways for a provider to avoid this liability are: a) through compliance with the directives, b) through compliance with instructions of the carrier, and c) through careful creation and retention of billing support documents. In addition to general identification information, these records should indicate each test run, when the test was run, and, if tests were run on separate days, why the sample was split up.

***Physician Owners and the Structuring of Joint Ventures.*** The Genesee County Mental Health and or the Genesee County Public Health must be aware that providers who have physician investors are subject to requirements designed to prevent physicians from benefiting from referrals to entities in which they have a financial interest. The provider and physicians involved must insure that the overall structure of the deal complies with the requirements related to ownership interest, investment structure, and reporting requirements.

## X WORK PLAN

Each year Genesee County Corporate Compliance Committee will convene to develop a **<u>County Wide Compliance Work Plan.</u>** The committee will review accomplishments from the prior year plan and propose updated amendments to existing compliance policy procedures and practices.