# Compliance Manual Policies and Procedures (Including Medicaid Compliance Program)

## Niagara County Department Of Health Nursing Division

January 2022

## Purpose of Medicaid Compliance Program

The Niagara County Department of Health Nursing Division has developed a Medicaid Compliance Program as required by New York State Social Services Law Sec. 363-d subd. 2 (See Attachment #1) and 18NYCRR 521.3(c) (See Attachment #2). This program reaffirms the commitment of Niagara County Department of Health Nursing Division to abide by high legal and ethical standards in connection with the delivery of health and human services to the people they serve.

To that end, Niagara County Department of Health Nursing Division has developed the following Standards of Conduct and Policies and Procedures for the implementation of the Medicaid Compliance Program. These documents provide guidance to all employees, independent contractors and Board of Health members regarding the operation of the Compliance Program, the available mechanisms through which compliance issues can and should be reported, identifies how to communicate compliance issues to appropriate compliance personnel and describes how potential compliance problems are investigated and resolved.

This program was established to fulfill this Division's legal responsibility to submit accurate claims to Medicaid and other payors, to identify and prevent illegal conduct and to minimize losses from false claims, to prevent unwanted events from occuring, to help the Division learn about these events before they occur and if the event occurs without the Division learning about it first, this plan will help mitigate or reduce negative effects by demonstrating that these events are exceptions.

Each employee, contractor and Board of Health member of Niagara County Department of Health Nursing Division is responsible for adhering to both the Standards of Conduct and the Policies and Procedures of the Compliance Program

# SECTION I
# STANDARDS OF CONDUCT

## Introduction –Code of Conduct

Niagara County has established a Code of Ethics. This Code of Ethics is enacted pursuant to Article 18 of the General Municipal Law. It is the purpose of this Code to encourage public trust and to establish minimum standards of ethical conduct for County officers, employees, and other appointed officials, to afford them clear guidance, and to ensure that County government is so free from improper influence as to assure public confidence. (See Attachment #3 Niagara County Code of Ethics)

In keeping with its ethics code, the Niagara County Department of Health Nursing Division has developed a Compliance Program to reaffirm the commitment of Niagara County Department of Health Nursing Division to abide by high legal and ethical standards in connection with the delivery of health care services. To that end, Niagara County Department of Health Nursing Division has developed this Medicaid Compliance Manual, which sets forth the Standards of Conduct and Policies and Procedures to be followed by all Nursing Division employees and contractors who furnish services to Niagara County Department of Health Nursing Division.

Reportable incidents based on the Medicaid Compliance Plan include:

- Any employee or contractor who acquires information that gives him or her reason to believe that another employee or contractor is engaged in or plans to engage in conduct prohibited by the Medicaid Compliance Plan;

- Any information indicating that any other person or entity associated with Niagara County Department of Health Nursing Division plans to violate the standards of conduct or the policies and procedures contained in the Medicaid Compliance Plan or any other policies and procedures;

- Anyone who is instructed, directed, or requested to engage in conduct prohibited by the Medicaid Compliance Plan;

- Any other issues about which employees or contractors believe involve questionable activity;

Employees or contracted providers aware of any incidents which fit the description above must immediately refer to the Medicaid Compliance Plan section on Reporting Requirements and take action.

This Medicaid Compliance Manual, of course, cannot cover every situation you may encounter, and it is not intended to. When the proper course of action is unclear you should seek the guidance of your immediate supervisor or the Compliance Officer, who has been designated to administer the Compliance Program outlined in the Manual.

## 1.1 Niagara County Department of Health Nursing Division's Commitment to the Delivery of High Quality Programs and Services

1.1.1 Niagara County Department of Health Nursing Division Provides Quality Programs and Services. Niagara County Department of Health Nursing Division:

- Will provide programs and services in compliance with all applicable federal and state regulatory requirements.
- Is committed to providing a high quality of care and services to its program recipients and every other patient as well through the delivery of services in a responsible, reliable, ethical, and appropriate manner.
- Is committed to the goal of excellence in service delivery and programming with sensitivity to all recipient needs.
- Expects that services and decisions rendered by staff and contractors will be made in accordance with customary and recognized standards of care.

1.1.2 Niagara County Department of Health Nursing Division treats service/program recipients with dignity and respect.

Niagara County Department of Health Nursing Division requires that service and program recipients and all others be treated with dignity and respect.
Employees and contractors of Niagara County Department of Health Nursing Division must maintain the confidentiality of all recipient related information, as required by law.

1.1.3 Niagara County Department of Health Nursing Division does not discriminate

Niagara County Department of Health Nursing Division provides programs and services to individuals in accordance with program eligibility and/or individual needs, and complies with applicable Federal civil rights laws and does not descriminate on the basis of race, color, national origin, age, disability or sex. Niagara County Department of Health does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, or gender identity).

1.1.3 Revised Janury 2022

## 1.2 Integrity of Business Practices

1.2.1 Niagara County Department of Health Nursing Division will conduct its business in an ethical manner

Each employee or contractor of Niagara County Department of Health Nursing Division must:

- Maintain a high level of integrity and honesty in business conduct.

- Avoid any conduct that could reflect adversely on the integrity of Niagara County Department of Health Nursing Division.

- Perform all duties on behalf of Niagara County Department of Health Nursing Division in a manner that the employee or contractor reasonably believes to be in the best interest of Niagara County Department of Health Nursing Division.

1.2.2 Niagara County Department of Health Nursing Division will market its services in an ethical manner

Niagara County Department of Health Nursing Division will present itself to the community through its marketing activities in a manner consistent with its mission and capabilities.

Niagara County Department of Health Nursing Division will not engage in any unethical, abusive, or illegal marketing or advertising practices in connection with the offering or provision of health care services.

## 1.3 Compliance with Regulatory Requirements Related to the Provision of Health Care Services

1.3.1 Familiarity and compliance with regulatory requirements

Niagara County Department of Health Nursing Division and its employees and contractors are subject to numerous federal and state regulatory requirements relating to the provision of health care services by Niagara County Department of Health Nursing Division, and the submission of claims for payment for such health care services on behalf of Niagara County Department of Health Nursing Division.

Employees and contractors of Niagara County Department of Health Nursing Division are expected to be familiar with the penalties for failure to comply with such requirements.

Any question regarding federal and state regulatory requirements should be directed to the employee's supervisor or the Compliance Officer.

1.3.2 Familiarity and compliance with regulatory information distributed in writing and/or via training

From time to time, Niagara County Department of Health Nursing Division will distribute written information and/or provide in-house training sessions regarding federal and state regulatory compliance issues relating to the provision of health care services by Niagara County Department of Health Nursing Division, or reimbursement by government health care programs for such services.

These issues will include those that are identified as a result of internal audit and monitoring activities, or identified as potential areas of concern by the Center for Medicaid and Medicare Services ("CMS"), the Office of the Inspector General of the Department of Health and Human Services ("OIG"), or other federal or state government agencies.

Employees and contractors should review such information and address any questions to the employee's supervisor and/or the Compliance Officer.

1.3.3 Licenses, certifications, approvals and accreditation

Niagara County Department of Health Nursing Division maintains all licenses, certifications, approvals and accreditation necessary for the operation of each health care facility, service, or department within the Niagara County Department of Health Nursing Division health care system.

In addition, Niagara County Department of Health Nursing Division will comply with all applicable requirements for participation in government health care programs, including Medicare and Medicaid, and private health insurance plans to which claims or requests for payment for health care services are submitted on behalf of Niagara County Department of Health Nursing Division.

## 1.4 Billing Compliance

1.4.1. Guidelines for billing

1.4.1.1 Niagara County Department of Health Nursing Division bills only for medically reasonable, necessary and appropriate items and/or services

Niagara County Department of Health Nursing Division only bills for medically reasonable, necessary and/or appropriate health care items and services rendered or provided.

Niagara County Department of Health Nursing Division must comply with specific billing requirements for government programs and third party payers.

Niagara County Department of Health Nursing Division expects its employees and subcontractors to be familiar with the billing requirements under government programs and private insurance plans for all health care items and services provided by Niagara County Department of Health Nursing Division.

1.4.1.2 Bill must be accurate and complete

Employees and contractors of Niagara County Department of Health Nursing Division have an obligation to ensure that all bills submitted to patients, government programs, and other payers are accurate and complete.

All invoices, bills, claims, records and reports submitted to patients, government programs, or other payers in connection with request for payment for health care services rendered should be clear and accurate and should provide sufficient information and documentation to substantiate:

The particular health care services rendered, including:

- The medical necessity of such services, and

- The cost for such services

Each Patient's medical record should completely and accurately document:

- The specific health care services rendered to the patient, and
- The identity of the health care professional(s) involved in the rendering of such services.

1.4.1.3 Statements must be true and accurate

All employees and contractors of Niagara County Department of Health Nursing Division must exercise care in any written or oral statement made to any government agency or any third party payer.

Niagara County Department of Health Nursing Division will not tolerate false or misleading statements by employees or contractors to a government agency or any third party payer.

Deliberate misstatements to government agencies or other third party payers expose the employee or contractor involved to severe sanctions, up to and including termination of employment, immediate termination of contract, and civil or criminal penalties.

## 1.5 Relations with Government Suppliers

1.5.1 Niagara County Department of Health Nursing Division expects compliance from contractors

It is the policy of Niagara County Department of Health Nursing Division to require compliance from contractors. Such contractors include all persons and entities that provide billing services for Niagara County Department of Health Nursing Division.

Such contractors must be familiar with and comply with all applicable federal and state regulatory requirements and must conduct all business in an ethical manner.

All agreements between Niagara County Department of Health Nursing Division and contractors that provide direct patient services to Niagara County Department of Health Nursing Division must include a signed agreement indicating that the contractor:

- Has reviewed the standards of conduct and policies and procedures outlined in this Compliance Manual.
- Agrees to comply with such standards of conduct and policies and procedures.
- Will require compliance with such standards of conduct and policies and procedures by all persons who provide services to Niagara County Department of Health Nursing Division on behalf of such contractor.

## 1.6 Human Resources

### 1.6.1 Equal Employment Opportunities

Niagara County Department of Health Nursing Division is committed to and will provide equal employment opportunities to all persons regardless of race, color, religion, sex, national origin, age, disability, sexual preferences or veterans' status.

It is the policy of Niagara County Department of Health Nursing Division to comply with all federal and state laws concerning equal employment opportunity.

This policy of equal opportunity is applicable to all aspects of employment including but not limited to hiring, promotion, transfer, compensation, benefits, training, lay off, recall, corrective actions, and suspensions.

### 1.6.2 Niagara County Department of Health Nursing Division does not tolerate discrimination or harassment

Niagara County Department of Health Nursing Division expects everyone associated with Niagara County Department of Health Nursing Division to treat co-workers and patients with respect and courtesy.

Niagara County Department of Health Nursing Division will not tolerate having its employees, contractors or patients subject to harassment or discrimination on the basis of any of the factors listed above, and will discipline those who violate this policy or terminate the contract of any contractors.

Harassment specifically includes unwelcome sexual advances, requests for sexual favors, or other verbal, graphic, or physical conduct of a sexual nature.

### 1.6.3 Drugs, narcotics, alcohol

#### 1.6.3.1 Prohibitions and discipline

It is the policy of Niagara County Department of Health Nursing Division to maintain a workplace free from the unlawful use of controlled substances.

Niagara County Department of Health Nursing Division prohibits the use, sale, manufacture, dispensing, or possession of illegal drugs and narcotics by employees and contractors, and the writing of unauthorized prescriptions by professional staff members, whether on or off Niagara County premises.

It is also the policy of Niagara County Department of Health Nursing Division that employees and contractors must not possess, consume, or be under the influence of alcoholic beverages during regular business hours or while on call.

Niagara County Department of Health Nursing Division will discipline or discharge employees in accordance with Niagara County Human Resources policy and collective bargaining agreements, or immediately terminate contractors who violate this policy.

1.6.3.2 Reporting

Any employee or contractor reporting to work or discovered at work in a condition that suggests that he or she is under the influence of narcotics, drugs, or alcohol will not be permitted to report to or remain on the job, and may be subject to corrective action, including suspension or termination in accordance with Niagara County Human Resources policies and collective bargaining agreements.

The matter will be referred to the Niagara County Health Department Public Health Director, Niagara County Human Resources and/or the Employee Assistance Program for review and will be handled in accordance with current Niagara County policies and procedures regarding substance abuse.

1.6.4 Qualifications of health care professionals

Niagara County Department of Health Nursing Division, through its credentialing processes, will make appropriate efforts to verify that all physicians, nurses, and other health care professionals who provide health care services on behalf of Niagara County Department of Health Nursing Division are appropriately licensed and/or certified under state law to provide such services.

All physicians, nurses, and other health care professionals must satisfy the applicable requirements for providing services to beneficiaries of government health care programs, including Medicare and Medicaid.

The licensing credentials of these professionals are checked upon initiation of a contract. Checking credentials and maintaining proof of credentials is a departmental responsibility. Credentials are checked using a software program from Kinney and Associates. This is checked at hire and monthly thereafter for all providers. Sites that are accessed include: www.omig.state.ny.us and www.oig.hhs.gov.

Monthly billing by providers will be withheld and not claimed until this information is current in our database. It is the responsibility of the administrative secretary to communicate with billing until any issues have been resolved. If issues cannot be resolved, payment will not be made for associated claims.

## 1.7 Document Retention and Medical Records Privacy

In order to ensure that Niagara County Department of Health Nursing Division keeps those documents required by law and necessary to its operations, employees and contractors of Niagara County Department of Health Nursing Division should adhere to the following guidelines on document retention.

1.7.1 Requirements of government programs and other third party payers.

Niagara County Department of Health Nursing Division will comply with the document retention requirements of state or federal government health care programs and other third party payers with regard to records relating to the provision of health care services to beneficiaries of such government programs or the health care reimbursement plans of such third party payers.

The Records Access Officer for Niagara County Department of Health Nursing Division maintains document retention requirements. Currently, the Office of the County Clerk handles the duties of the Records Officer. Files are generally maintained at the Niagara County Records Facility.

### 1.7.2 Requirements of state and federal law

Niagara County Department of Health Nursing Division will comply with the document retention requirements under state and federal law and regulations with regard to all medical, financial, and administrative records concerning health care services.

No employee or contractor should ever destroy or alter any documents in anticipation of a request for those documents from any government agency or court.

If any employee or contractor believes that such conduct has occurred, or may occur, then the employee or contractor should immediately contact 1) his or her immediate supervisor, 2) the Compliance Officer or 3) the Niagara County Compliance Hotline (716) 278-1935.

### 1.7.3 Patient confidentiality and privacy

All medical records concerning patients of Niagara County Department of Health Nursing Division will be maintained as confidential and will be disclosed to third parties only as required by state or federal law.

## 1.8 Government Investigations

It is the policy of Niagara County Department of Health Nursing Division to comply with applicable laws.

It is the policy of Niagara County Department of Health Nursing Division to comply with all applicable laws and to comply with all lawful and reasonable requests made in a government investigation.

Niagara County Department of Health Nursing Division expects its employees and contractors to provide truthful responses to government inquiries.

### 1.8.1 Protection of legal rights is essential

If any employee or contractor receives an inquiry, a subpoena, or other legal document regarding the business of Niagara County Department of Health Nursing Division, whether at home or in the workplace, from any governmental agency, it is essential that the legal rights of Niagara County Department of Health Nursing Division and of the personnel involved be protected.

If an employee or contractor should receive such legal document, then he or she should notify the Niagara County Department of Health Division Director, Public Health Director and/or supervisor.

1.8.2 Investigatory interviews

In conducting investigations pursuant to the Compliance Plan, an assessment must be made of the potential rights or lack thereof, on the part of individual officers, employees, to representation prior to commencing an investigatory interview where such an individual could be suspected of wrongdoing.

## 1.9 Reporting of compliance issues

1.9.1 How to report concerns regarding compliance issues

All employees and contractors have a duty to report suspected misconduct in connection with alleged unethical or illegal behavior related to billing and the Medicaid Compliance Plan, without fear of retaliation, intimidation or breach of confidentiality.

If a Niagara County Department of Health Nursing Division employee, contractor or Board of Health member has concerns regarding any ethics or compliance issue, including any of the standards of conduct, policies and/or procedures described in this Compliance Manual, that employee or contractor should immediately contact one of the following:

His or her supervisor, Division Director or Public Health Director

The Niagara County Department of Health Nursing Division Compliance Officer: (716) 278-8596

The Niagara County Department of Health Nursing Division Compliance Helpline: (716) 278-1935

Upon receiving a complaint regarding an ethics or compliance issue, a written report will be generated by the person contacted. (See Attachment #4) This report will be forwarded to the Compliance Officer within 24 hours of the initial contact. If the reporting party is not interested in having his or her name placed on the report, then the option of anonymity can be provided.

All reports regarding an ethics or compliance issue will be reviewed and investigated by the Compliance Officer within seven (7) days of receipt of a complaint.

On a quarterly basis, or more frequently as needed, the Division Director or designee will review all reports reviewed/investigated by the Compliance Officer.

All calls to the Compliance Helpline will be treated with confidentiality.

### 1.9.2 Helpline

1.9.2.1 Purpose of Helpline

In order to provide employees and contractors with every avenue possible through which to raise their concerns, Niagara County Department of Health Nursing Division has established a Compliance Helpline at (716) 278-1935. This helpline number is available twenty four hours per day, seven days per week.

1.9.2.2 When to use Helpline

If an employee or contractor of Niagara County Department of Health Nursing Division reasonably suspects or knows of violations including:

Applicable legal requirements;

The Niagara County Department of Health Nursing Division standards of conduct and policies and procedures contained in this Compliance Manual;

Any employee or contractor who acquires information that gives him or her reason to believe that another employee or contractor is engaged in or plans to engage in conduct prohibited by the Compliance Manual;

Any information indicating that any other person or entity associated with Niagara County Department of Health Nursing Division plans to violate the standards of conduct or the policies and procedures contained in the Compliance Manual or any other policies and procedures;

Anyone who is instructed, directed, or requested to engage in conduct prohibited by the Compliance Manual;

Any other issues about which employees or contractors believe involves questionable activity;

Other compliance policies and procedures, which may be developed by the Niagara County Department of Health Nursing Division from time to time;

Then this employee or contractor must immediately contact their immediate supervisor, the Division Director, Public Health Director, the Compliance Officer or the Compliance Helpline.

1.9.2.3 Confidentiality of Helpline

All calls received on the Compliance Helpline will be treated as confidentially as possible.

Niagara County Department of Health Nursing Division will not permit any retaliation against or intimidation of any employee or contractor for such reporting.

1.9.2.4 Anonymous Reporting

If the reporter wishes to remain anonymous, they can report suspected Medicaid fraud or abuse directly to the Office of the Medicaid Inspector General. The toll-free New York State hotline number (1-877-873-7283) will be conspicuously posted (see attachment #5) for staff or other concerned parties to report suspected fraud or abuse. Allegations can also be filed online at www.omig.ny.gov. The form to file an allegation is also available to staff through this manual. (See attachment #6) Other ways to contact OMIG include by telephone (518) 408-0401, by fax (518) 408-0710, by email compliance@omig.ny.gov, or by mail at NYS OMIG – Bureau of Medicaid Fraud Allegations, 800 North Pearl Street, Albany, NY 12204.

1.9.3 Retaliation against or intimidation of employees or contractors for reporting is prohibited

Niagara County Department of Health Nursing Division will not permit any retaliation against or intimidation of any employee or contractor for reporting compliance issues; however, abuse of the Helpline will not be tolerated.

Employees or contractors reporting compliance issues may be covered/protected under various provisions in both State and Federal law. Most notably the Qui Tam provisions of the False Claims Act address these issues. The "qui tam" means that an individual is bringing suit on behalf of the state and for him/herself. Other federal and state laws also incorporate so-called "whistleblower" provisions. For a listing of some of these applicable laws, please refer to Attachment #7.

## 1.10 List of Phone Numbers

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|---|---|
| Compliance Helpline | (716) 278-1935 |
| Niagara County Department of Health Nursing Division Compliance Officer | (716) 278-8596 |
| New York State Fraud Hotline | (877) 873-7283 |
| Office of Medicaid Inspector General | (518) 408-0401 |

## 1.11 Compliance Officer and Committee Members

Niagara County Department of Health Nursing Division

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|---|---|
| Compliance Officer:<br>(under the direction of Public Health Director,<br>Division Director, Human Resources and<br>Niagara County Risk Manager) | Stacy Knott |
| Compliance Committee Members: | Adrienne Kasbaum<br>Donald E. Shawver, Jr.<br>Andrea Ahart |

Phone Numbers, Officers & Member Names Changed 7-2021

# SECTION II
# POLICIES AND PROCEDURES

Below are some specific policies and procedures that relate to the implementation and operation of the Medicaid Compliance Program in Niagara County Department of Health Nursing Division.

## 2.1 Medicaid Compliance Committee and Medicaid Compliance Officer

### 2.1.1 Medicaid Compliance Committee Responsibility

The Medicaid Compliance Committee will have overall responsibility for managing and overseeing the Compliance Program.

The Compliance Committee, under the direction of the Medicaid Compliance Officer (MCO), will be responsible for operating the Compliance Program on a daily basis, and will have at its disposal appropriate resources to discharge its responsibilities under the Compliance Program.

The Compliance Committee, under the direction of the Compliance Officer, will assume responsibility for investigating any violation of the Compliance Program, in accordance with the procedures outlined in this document under “Disciplinary Procedures”.

### 2.1.2 Medicaid Compliance Officer Role and Responsibility

The Nursing Operations Manager of the Nursing Division is responsible for overseeing the Medicaid Compliance Program. The Nursing Operations Manager will work under the direction of the Division Director, Public Health Director, County Attorney, Board of Health, Human Resources and Risk Manager, as needed.

The County Attorney shall render all legal opinions, may advise the Compliance Officer on developments and changes in the laws, regulations and policies that affect the Medicaid Compliance Plan and, in conjunction with Human Resources, advise on any enforcement or discipline pertaining to reports of misconduct.

The duties of the Compliance Officer include:

- oversight and implementation of the Medicaid Compliance Plan
- reports to Director of Nursing (DON), Public Health Director and Board of Health, as directed
- revision of the Medicaid Compliance Plan to meet Federal and State laws and regulations
- development and implementation of education and training on the Medicaid Compliance Plan for employees, contracted staff and Board of Health
- serve as a contact point for employees or contractors to report alleged violations, while maintaining anonymity of the reporting individual and the confidentiality of the report

The Compliance Officer will serve as an ombudsman to whom employees and contractors should report alleged violations of standards of conduct set forth in the Medicaid Compliance Manual.

Niagara County Department of Health Nursing Division will instruct its employees and contractors to report to the Compliance Officer, Division Director or Public Health Director any and all information regarding a suspected, known or potential violation of its Medicaid Compliance Manual through direct contact or through the Compliance Helpline.

To facilitate such disclosure, Niagara County Department of Health Nursing Division will display a notice at its facilities on the necessity of promptly reporting suspected misconduct or deficient practices.

The Compliance Officer will make all reasonable efforts to maintain the anonymity of the reporting individual and the confidentiality of the report.

The Compliance Officer will be responsible for training efforts regarding the Compliance Program for the Nursing Division.

## 2.2 Medicaid Compliance Helpline

### 2.2.1 Purpose of Helpline and number

Niagara County Department of Health Nursing Division will maintain a telephone number to receive communications from employees, contractors and members of the governing body, in connection with alleged unethical or illegal behavior on the part of any officer, agency official, employee, contractor or representative of Niagara County.

The Medicaid Compliance Helpline ("the Helpline") number is (716) 278-1935.

When calling the above mentioned number the caller will be asked to leave a message on a password coded secure voice mail system. The Compliance Officer will check this voice mail system daily during the workweek (Monday through Friday, exclusive of holidays.)

### 2.2.2 Logging calls to the Helpline

All calls to the Helpline will be logged and a report will be made on each call using the compliance complaint form.

Calls can be made on an anonymous basis.

All calls will be reported to the Compliance Officer who will ensure appropriate follow-up in connection with the calls.

The Corporate Compliance Officer also will maintain records to:

- Track the nature, topic, and source of calls.
- Assess the necessity for amendments to the Medicaid Compliance Manual.

- Consider changes in other policies and procedures.

- And otherwise monitor the Helpline.

2.2.3 Responding to the caller

If the identity of the caller is known, then the Corporate Compliance Officer will:

- Contact the caller within seven (7) days of the call.

- Inform the caller of the status of the Compliance Officer's review of the matter, (review performed in conjunction with the Division Director, Public Health Director, County Attorney and Risk Manager).

- Provide the caller with an opportunity to discuss any additional information known by the caller regarding the subject matter of the call.

If the caller wishes to remain anonymous but wants a follow-up on his/her concerns, then the Compliance Officer will arrange a date and time for the caller to call back.

2.2.4 Response of Medicaid Compliance Committee

The Compliance Committee, in conclusion with the Division Director and/or Public Health Director, Niagara County Attorney and Risk Manager as appropriate, will make all reasonable efforts to determine the appropriate course of action in connection with each call within seven (7) days of the call.

This response will be documented and maintained in the Helpline log.

The call may be referred to another Department or may result in an investigation by the Compliance Committee, in accordance with the procedures set forth in "Investigations and Corrective Action," below.

## 2.3 Training and Implementation of Medicaid Compliance Program

2.3.1 Responsibilities for implementation

The Medicaid Compliance Officer will be responsible for the Compliance Program's implementation and for ensuring that all employees, contractors, and members of the governing body are fully informed about the Medicaid Compliance Program.

2.3.2 Training and Distribution of Medicaid Compliance Manual

Training sessions will be conducted and the Medicaid Compliance Manual will be reviewed and made available to all current employees and to all new employees within ninety (90) of their hire or appointment date. During orientation, all new employees shall review, at a minimum, the Medicaid Compliance Plan and the applicable Federal and State regulatory requirements relating to the provision of Medicaid services by Niagara County Department of Health Nursing Division.

2.3.3 Signing the Medicaid Compliance Certification

During these training sessions, each employee will be given a Medicaid Compliance Certification for the employee to sign. (See Attachment #8)

The Medicaid Compliance Certifications will be kept in the employee's personnel file.

2.3.4 Annual affirmation of compliance

Each employee will be required annually to execute a statement affirming that he/she agrees to abide by the standards of conduct and policies and procedures contained in this Medicaid Compliance Manual. (See Attachment #8) This statement will be kept in the employee's personnel file. (See Attachment #9)

2.3.5 Service Agreements with contractors

All service agreements between Niagara County Department of Health and contractors that furnish direct patient care services to Niagara County Department of Health Nursing Division must include a signed statement indicating the contractor:

- Has reviewed the standards of conduct and policies and procedures outlined in this Medicaid Compliance Manual.

- Will require compliance with such standards of conduct and policies and procedures by all persons who provide services to Niagara County Department of Health Nursing Division on behalf of such contractor.

Contracted providers may be required to participate in training programs relating to the Niagara County Department of Health Nursing Division Medicaid Compliance Plan.

2.3.6 Purpose and responsibility

To insure that employees are familiar with the Compliance Program, there will be an ongoing communication with regard to the Compliance Program.

The Medicaid Compliance Officer will be responsible for coordinating the training efforts for the Compliance Program.

2.3.7 Initial training and annual follow-ups

The initial training for all employees shall review, at a minimum, the Medicaid Compliance Manual.

The Medicaid Compliance Committee, at its discretion, may require that a contractor with a Service Agreement with Niagara County Department of Health Nursing Division and persons, who provide services to Niagara County Department of Health Nursing Division on behalf of such contractor, must participate in training programs relating to the Niagara County Department of Health Nursing Division Medicaid Compliance Program.

Each year following the initial implementation of the Compliance Program, all employees and professional staff members will be required to affirm in writing that they agree to abide by the standards of conduct and policies and procedures set forth in the Medicaid Compliance Manual. (See Attachment #8).

2.3.8 Communication of changes in Medicaid Compliance Program

The Medicaid Compliance Officer also will provide employees with written explanations of substantial changes in the applicable laws and Medicaid Compliance Manual.

The Compliance Officer will distribute in writing, or post in a conspicuous place, or email staff and mention at a staff meeting, any modifications of, or amendments to the Medicaid Compliance Manual.

If the Medicaid Compliance Officer determines that written materials are not sufficient to familiarize employees with the amendments to the Medicaid Compliance Manual, or changes in the applicable law, then interim training sessions will be conducted.

2.3.9 Ongoing communication about Medicaid Compliance Program

Employees will be provided periodic information about the Compliance Program. Compliance issues will be addressed at staff meetings, or more frequently if necessary, to keep staff members informed of any changes in policies and procedures and to review key components of the Compliance Manual

## 2.4 Modifying and Amending the Medicaid Compliance Program

2.4.1 Annual review of Medicaid Compliance Program

The Medicaid Compliance Committee will review the Compliance Program annually to determine whether it should be modified based on new legal requirements or the past experiences of Niagara County Department of Health Nursing Division with the Compliance Program.

If necessary, Niagara County Department of Health Nursing Division will:

- Modify or amend the Medicaid Compliance Program to increase the likelihood that it will prevent and detect violations of law.

- Disseminate the modifications or amendments electronically, in writing or shared at staff meetings.

2.4.2 Review of Medicaid Compliance Manual with each investigation
The Corporate Compliance Committee will review the Medicaid Compliance Manual in connection with each investigation.

If the review indicates that a provision has been ineffective or could be improved, then the Compliance Committee will make changes and, if necessary, recommend to the Public Health Director, Risk Manager and County Attorney the appropriate modification

or amendment to increase the likelihood that it will prevent and detect violations of law or the Compliance Program.

2.4.3 If approved by the Public Health Director, County Attorney and Risk Manager, such modification or amendment will be distributed electronically, in writing or shared at staff meetings with all Niagara County Department of Health Nursing Division employees and contractors.

2.4.4. Amendment of Medicaid Compliance if Niagara County Department of Health Nursing Division programs expand

If Niagara County Department of Health Nursing Division expands its programs to provide additional health care items or services, then the Medicaid Compliance Program will be amended, if necessary, to govern the new activity.

The Compliance Program will include standards and procedures to prevent and detect violations of the laws applicable to the new activity.

Any amendments will be disseminated electronically, in writing or shared at staff meetings.

2.4.5. Review of appointment of Compliance Officer; modifications and amendments to Medicaid Compliance program

The Director of Nursing Services will review the appointment of the Medicaid Compliance Committee annually.

If necessary to maintain the effectiveness of the Medicaid Compliance Program, the Director of Nursing Services will replace the Medicaid Compliance Officer/Committee.

**2.5 Investigations and Corrective Action**

2.5.1 Investigation

2.5.1.1 Procedure for investigation

Upon receiving report of a known or suspected violation of the Medicaid Compliance Manual or other misconduct:

- The Medicaid Compliance Officer will notify the Director of Nursing Services, Public Health Director, and if necessary, the county attorney and Niagara County Human Resources and Risk Manager.

- The Medicaid Compliance Committee will promptly investigate the matter to determine whether a violation of the Medicaid Compliance Manual, or other wrongdoing or misconduct has, in fact, occurred.

2.5.1.2 Components of investigation

The Medicaid Compliance Committee will have use of any available resources necessary for a thorough investigation of alleged violations of the Medicaid Compliance Manual or other wrongdoing or misconduct. The investigation may include:

- Interviews of relevant personnel, including the person making the report if their identity is known.
- A review of relevant documents.
- Engagement of outside counsel or experts as needed (under the direction of the Public Health Director).

The Public Health Director will be kept apprised of the progress of the investigation.

After the preliminary investigation, the MCO will consult with the Division Director, Public Health Director and/or Niagara County Attorney and Risk Manager as needed, in order to determine the direction of any further investigation, enforcement or discipline.

2.5.1.3 Report of the investigation

At the conclusion of any investigation by the Medicaid Compliance Committee, a written report will be prepared, under the direction of the county attorney, if appropriate, for the Public Health Director. The report will describe:

- The substance of the allegations.
- The evidence uncovered by the investigation.
- The Medicaid Compliance Committee's findings.

2.5.1.4 Recommendation of corrective action

If, as a result of the investigation, the Medicaid Compliance Committee determines that a provision of the Medicaid Compliance Manual has been violated, or that other misconduct or wrongdoing has occurred, then the Compliance Committee's report will recommend to the Public Health Director the corrective solution warranted under the circumstances.

With the assistance of the Medicaid Compliance Officer, the Division Director, the Public Health Director, County Attorney, Risk Manager and Human Resources, corrective action will be implemented, including:

- Any necessary disciplinary action.

- Communications to employees and contractors regarding any modifications to the Compliance Plan

- Directing that any appropriate refunds to government or private payers be made.

In addition, in consultation with legal counsel, and depending on the nature of the findings, the Division may elect to self-disclose the findings to the OMIG. Factors that will be considered in self-disclosure include:

- The exact issue

- Patterns or trends that may be a problem with the billing system

- The period of non-compliance

- The history of the contracted provider (i.e. substantial routine errors)

Each incident will be considered on an individual basis. If it is decided to self-disclose, the Division will follow the guidance from OMIG present in the Self-disclosure Guidance (August 2012) and use appropriate forms, as indicated in the guidance. (See attachment #10) If the division decides to self-disclose, it will be completed within 60 calendar days from the identification of overpayment.

2.5.1.5 Medicaid Compliance Committee Quarterly Reports

The Nursing Division Director and, when necessary, legal counsel will report quarterly to the Niagara County Department of Health Board of Health a year-to-date summary of:

- All reports of alleged violations of the Medicaid Compliance Manual, or other wrongdoing or misconduct.

- The nature of the alleged violation.

- The findings of any investigation.

- Any corrective action taken.

## 2.6 Niagara County Department of Health Nursing Division Does Not Pay for Referrals

2.6.1 Compliance with federal and state laws

Any financial or other business arrangement between Niagara County Department of Health Nursing Division and physicians or other health care professionals or providers must be structured to comply with applicable federal and state fraud and abuse laws.

2.6.2 Refer questions to legal counsel

If questions arise regarding whether a proposed business arrangement is in compliance with federal or state laws that prohibit payments in exchange for the purchase of items or services or for the referral of patients, legal counsel must be consulted in order to determine whether the proposed arrangement is acceptable. Legal counsel for Niagara County Department of Health Nursing Division is the Niagara County Attorney. Issues regarding proposed arrangements can be referred to the Compliance Officer or directly to the Niagara County Attorney. The phone number for the County Attorney is (716) 439-7105.

## 2.7 Niagara County Department of Health Nursing Division Does Not Pay Patients

2.7.1 Guidelines for appropriate financial accommodation of patients **Revised 2.7.1 December 2019**

Under appropriate circumstances, Niagara County Department of Health Nursing Division may provide appropriate financial accommodation (such as allowing monthly payments over time) or may waive patient co-payment or deductible amounts based on an assessment of the individual patient's financial condition and a determination that the payment of such a co-payment or deductible amounts would cause a financial hardship for the patient.

Any such monthly payment arrangements or waivers of co-payment or deductible amounts on the basis of financial hardship must be in accordance with established departmental policies and procedures

## 2.8 Discovery and Reporting an Error or Inaccuracy in a Claim for Payment

Any employee or contractor of Niagara County Department of Health Nursing Division who discovers an error or inaccuracy in any claim for payment for health care services that has been submitted or will be submitted to a patient, government program, or other payer should alert his or her immediate supervisor, the Division Director or the Compliance Officer immediately. The Compliance Officer will review the matter and will inform the employee or contractor who made the report as soon as practical regarding whether the matter was resolved and, if so, how the matter was resolved.

The Medicaid Compliance Officer will log a discovery of an error. Entries into this log will include the date of the discovery of the error, the name of the person making the discovery, the nature of the error, the status/remediation and actions taken related to this matter. (See Attachment #11)

## 2.9 Correcting Any Identified Inconsistencies

In order to correct any identified inconsistencies with current billing practices, these steps will be taken:

- The Medicaid Compliance Officer will document the inconsistency in a log maintained by that division.

- A corrective action plan will be prepared, which will include a description of any in-house training that will be provided to billing personnel in order to address the identified billing compliance issues.

- Participation by billing personnel in any such training programs will be documented.

- All billing policy changes implemented in order to address identified billing compliance issues will be documented.

- Legal counsel will be obtained, as necessary.

## 2.10 Billing Personnel

### 2.10.1 Responsibility of billing personnel

Niagara County Department of Health Nursing Division requires all billing personnel to be knowledgeable regarding the billing policies and procedures relating to health care services furnished by Niagara County Department of Health Nursing Division established by government programs and private third party payers.

Niagara County Department of Health Nursing Division is committed to providing/authorizing involvement in training and in-services to billing personnel to help keep them up to date on billing policies and procedures. The department and employees should share information on any available training opportunities.

### 2.10.2 Responsibility of the Billing Supervisor

All questions regarding billing requirements should be directed to the Billing Supervisor. If this individual is unavailable, then an employee should bring a question to their immediate supervisor or the Division Director, as appropriate.

If the Billing Supervisor is unable to answer billing questions that arise, then he or she or a designee should contact the payer directly for additional information and/or clarification regarding the appropriate billing requirements, including:

- New York State Department of Health/Medicaid;

- Centers for Medicare and Medicaid Services

- Other outside experts and legal counsel

If possible, all responses to such requests will be obtained in writing.

### 2.10.3 Billing information

Information regarding the applicable billing requirements of government programs and private third party payers can be accessed electronically via each payers' website or by contacting their provider representative.

Billing personnel will be notified immediately by the supervisor of any material changes to the applicable billing requirements of which the supervisor becomes aware or is notified.

2.10.4 Training related to changes in billing requirements

Billing personnel will stay appraised of applicable billing requirements through contact with the provider representative.

Individuals who know of any significant changes related to billing or other accounting functions should pass this information on to their immediate supervisor so that these items can be investigated, and if needed, training provided or arranged.

## 2.11 Records / Claims Monitoring

Niagara County Department of Health Nursing Division will develop procedures for pre-submission and post-submission auditing, which will include the auditing of a percentage of randomly selected STD and immunization records. A standardized audit tool will be utilized to record the audit results.

2.11.1 Pre-Submission review

Post-clinic record audits will:

- Include an audit completed with a comparison of the codes billed with the documentation provided in the medical record.
- Ensure that all items and services billed, and the medical necessity of such items and services, are adequately and accurately described and documented, including specification of diagnosis and other items critical to a reimbursement decision.
- Ensure that documentation includes who provided care.

The pre-submission audit will also include a procedure whereby:

- On a monthly basis, 10% of all charts to be claimed will be reviewed prior to submission, using the “To Be Billed” report.
- Questions regarding charts are directed to the appropriate health professional involved, and
- Appropriate personnel make any needed clarifications and/or amendments to the documentation relating to the claim.

Pre-submission audits will be retained in accordance with record retention guidelines.

2.11.2 The post-submission review

On a quarterly basis, a post-submission review will include a random audit of 10% of charts submitted for payment by Niagara County Department of Health Nursing Division over a specified period. (Billing Register Detail report)

The audit will include a comparison of the documentation in the patient's medical record with the service billed. If the documentation contained in the medical record does not support the services billed, then the supervisor will review the claim with the clinician to determine whether additional information is needed so that the medical record will accurately reflect the services that were in fact provided.

All entries in a patient's medical record must be made in accordance with the applicable Niagara County Department of Health Nursing Division medical records policies.

The post-submission review will include specific procedures for taking corrective action, including submitting revised bills or refunding overpayments, where appropriate.

A supervisor and/or Compliance Officer will document corrective action thoroughly.

Such documentation will be maintained in the Compliance Office files.

## 2.12 Disclosure by Employees and Applicants for Employment

2.12.1 Departures

When an employee of Niagara County Department of Health Nursing Division resigns voluntarily, the Niagara County Department of Health Nursing Division Director or Compliance Officer will contact the employee in order to determine whether he/she knows of any violation of the Corporate Compliance program.

## 2.13 Disciplinary Procedures for Employees

2.13.1 Violations prohibited; adherence required

Employees of Niagara County Department of Health Nursing Division are strictly prohibited from engaging in any activity that violates the Medicaid Compliance Program. Violations will be grounds for disciplinary action up to and including termination, depending on the circumstances of each violation. For employees who are members of CSEA, provisions of the collective bargaining agreement and Niagara County personnel policies will be followed. Disciplinary actions will be determined on a case-by-case basis in conjunction with Human Resources, the County Attorney and CSEA, as needed.

Discipline may involve direction from outside parties (i.e. OMIG, law enforcement, NYS DOH), for further investigation and/or prosecution.

Adherence to the Medicaid Compliance Manual, including the reporting responsibilities, will be a component of each employee's performance evaluation.

Niagara County Department of Health Nursing Division will not permit any retaliation against or intimidation of any employee for reporting compliance issues.

2.13.2 Causes for disciplinary action

Disciplinary action will be taken against employees who either:

- Authorize or participate directly in a violation of the Medicaid Compliance Manual.
- Deliberately fail to report a violation.
- Deliberately withhold relevant and material information concerning a violation of the Medicaid Compliance Manual.
- Report a compliance issue if an investigation reveals that he/she violated or participated in a violation of the Medicaid Compliance Manual.

Appropriate action will be taken to prevent recurrence.

2.13.3 Disciplinary action against violator's manager or supervisor

Disciplinary action may be taken against the violator's manager or supervisor, to the extent that the circumstances of the violation reflect inadequate leadership or a lack of diligence.

## 2.14 Contractor Termination

2.14.1 Violations prohibited; adherence required

Contractors of Niagara County Department of Health Nursing Division are strictly prohibited from engaging in any activity that violates the Medicaid Compliance Program.

Violations will be grounds for contract termination, depending on the circumstances of each violation. Additionally, the matter may be referred to an outside agency (i.e. OMIG, DOH) for further investigation and/or prosecution.

Adherence to the Medicaid Compliance Manual, including the reporting responsibilities, will be a component part of each review of the contractor's performance.

Niagara County Department of Health Nursing Division will not permit any retaliation against any contractor for reporting compliance issues.

2.14.2 Causes for action

Action will be taken against contractors who:

- Authorize or participate directly in a violation of the Medicaid Compliance Manual.
- Deliberately fail to report a violation.
- Deliberately withhold relevant and material information concerning a violation of the Medicaid Compliance Manual.

- Report a compliance issue if an investigation reveals that he/she violated or participated in a violation of the Medicaid Compliance Manual.

## 2.16 Assessment and Monitoring Function

### 2.16.1 Purpose and parameters of annual compliance assessment

Niagara County Department of Health Nursing Division will conduct an annual compliance program assessment in order to:

- Ensure that employees and contractors of Niagara County Department of Health Nursing Division are adhering to the Compliance Program and to all applicable federal and state regulatory requirements.

- Evaluate whether Niagara County Department of Health Nursing Division has fulfilled its commitment to regulatory compliance and business ethics.

The annual compliance audit will be conducted by or under the direction and supervision of the Medicaid Compliance Committee.

# SECTION III
# ATTACHMENTS

**Attachment 1: New York State Social Services Law**

§ 363-d. Provider compliance program.

1. The legislature finds that medical assistance providers may be able to detect and correct payment and billing mistakes and fraud if required to develop and implement compliance programs. It is the purpose of such programs to organize provider resources to resolve payment discrepancies and detect inaccurate billings, among other things, as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrences. The legislature accordingly declares that it is in the public interest that providers within the medical assistance program implement compliance programs. The legislature also recognizes the wide variety of provider types in the medical assistance program and the need for compliance programs that reflect a provider's size, complexity, resources, and culture. For a compliance program to be effective, it must be designed to be compatible with the provider's characteristics. At the same time, however, the legislature determines that there are key components that must be included in every compliance program and such components should be required if a provider is to be a medical assistance program participant. Accordingly, the provisions of this section require providers to adopt effective compliance program elements, and make each provider responsible for implementing such a program appropriate to its characteristics.

2. Every provider of medical assistance program items and services that is subject to subdivision four of this section shall adopt and implement a compliance program. The office of Medicaid inspector general shall create and make available on its website guidelines, which may include a model compliance program, that reflect the requirements of this section. Such program shall at a minimum be applicable to billings to and payments from the medical assistance program but need not be confined to such matters. The compliance program required pursuant to this section may be a component of more comprehensive compliance activities by the medical assistance provider so long as the requirements of this section are met. A compliance program shall include the following elements:

(a) written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(b) designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator and shall periodically report directly to the governing body on the activities of the compliance program;

(c) training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;

(d) communication lines to the responsible compliance position, as described in paragraph (b) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(e) disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for: (1) failing to report suspected problems; (2) participating in noncompliant behavior; or (3) encouraging, directing, facilitating or permitting non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;
(f) a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits; (g) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments; (h) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.

3. Upon enrollment in the medical assistance program, a provider shall certify to the department that the provider satisfactorily meets the requirements of this section. Additionally, the commissioner of health and Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that satisfactorily meets the requirements of this section.

(a) A compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this section, so long as such plans adequately address medical assistance program risk areas and compliance issues.

(b) A compliance program that meets Federal requirements for managed care provider compliance programs, as specified in the contract or contracts between the department and the Medicaid managed care provider shall be deemed in compliance with the provisions in this section, so long as such programs adequately address medical assistance program risk areas and compliance issues. For purposes of this section, a managed care provider is as defined in paragraph (c) of subdivision one of section three hundred sixty-four-j of this chapter, and includes managed long term care plans.

(c) In the event that the commissioner of health or the Medicaid inspector general finds that the provider does not have a satisfactory program within ninety days after the effective date of the regulations issued pursuant to subdivision four of this section, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

4. The Medicaid inspector general, in consultation with the department of health, shall promulgate regulations establishing those providers that shall be subject to the provisions of this section including, but not limited to, those subject to the provisions of articles twenty-eight and thirty-six of the public health law, articles sixteen and thirty-one of the mental hygiene law, and other providers of care, services and supplies under the medical assistance program for which the medical assistance program is a substantial portion of their business operations.

**Attachment 2 Compliance Program Required Provider Duties**

521.3 Compliance Program Required Provider Duties

(a) Every required provider shall adopt and implement an effective compliance program. The compliance program may be a component of more comprehensive compliance activities by the required provider so long as the requirements of this Part are met. Required providers' compliance programs shall be applicable to:

(1) billings;

(2) payments;

(3) medical necessity and quality of care;

(4) governance;

(5) mandatory reporting;

(6) credentialing; and

(7) other risk areas that are or should with due diligence be identified by the provider,

(b) Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter, a required provider shall certify to the department, using a form provided by the Office of the Medicaid Inspector General on its website that a compliance program meeting the requirements of this Part is in place. The Office of the Medicaid Inspector General will make available on its website compliance program guidelines for certain types of required providers.

(c) A required provider's compliance program shall include the following elements:

(1) written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;

(2) an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the governing body on the activities of the compliance program;

(3) training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;

(4) communication lines to the responsible compliance position, as described in paragraph (2) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(5) disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

(i) failing to report suspected problems;

(ii) participating in non-compliant behavior; or

(iii) encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced;

(6) a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries;

(7) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluation's and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;

(8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty, and seven hundred forty-one of the labor law.

**Attachment 3 Code of Ethics**

# CODE OF ETHICS
# FOR THE
# COUNTY OF NIAGARA

# A CODE OF ETHICS FOR THE COUNTY OF NIAGARA

## Table of Contents

# A CODE OF ETHICS FOR THE COUNTY OF NIAGARA

## SECTION 1. PURPOSE AND SCOPE

This Code of Ethics is enacted pursuant to Article 18 of the General Municipal Law. It is the purpose of this Code to encourage public trust and to establish minimum standards of ethical conduct for County officers, employees, and other appointed officials, to afford them clear guidance, and to ensure that County government is so free from improper influence as to assure public confidence. This Code shall be in addition to all other legal restrictions, standards, and provisions pertaining to the conduct of County officers and employees. Every provision of this Code, except as expressly limited, shall apply to every officer and employee of Niagara County, whether paid or unpaid, including members of any administrative board, commission, or other agency, and every County officer or employee paid from County funds provided, however, that no person shall be deemed to be a County officer or employee solely by reason of being a judge or justice of any court.

This Code of Ethics shall apply to all advisory boards, committees and commissions created by the Niagara County Legislature.

## SECTION 2. DISCLOSURE OF INTEREST; LEGISLATIVE ABSTENTION

1. Disclosure of interests regardless of conflict

The following individuals shall, by May 15th of every year or if newly elected or appointed within thirty (30) days after taking office file a statement with the Board of Ethics:

A. Every County Legislator or any other elected official to a Niagara County Office;
B. Members and Officers of the Industrial Development Agency (IDA);
C. Niagara Community College trustees;
D. Every County Political Party Chairman;
E. Candidates for County Elected Offices who file designating petitions for nominations at a primary election shall file such statement within seven (7) days after the last day allowed by law for the filing of designating petitions; and
F. County Employees who hold policy-making positions as annually determined by the appointing authority and set forth in writing during January 31st of each year:

Such statement shall be adopted by the County and include the following:

i. The name of any corporation for profit in which they, and/or their spouse, and/or minor children hold collectively 5% or more of the stock;
ii. Real property situated in Niagara County which they, their spouse, or minor children hold for profit or from which they, their spouse, or minor children receive rents or income, excepting such real property as is maintained for use as their residence or the residence of their spouse or minor children, as the case may be;
iii. Self-employment or employment by, or membership in or on the board of directors of, any corporation, partnership, association, person, or other entity from which the employee derives gross income in excess of $500.00 per year.

Any such County officer or employee who does not have any such interests shall so file a statement to that effect. Such statements of disclosure shall be, indexed and maintained on file in an appropriate manner by the Board of Ethics.

It shall be the responsibility of the Director of Human Resources, prior to January 31 of each year, to review the list of those persons who, in the Director's judgment, are "policy making employees" and to forward any

recommendations for additions and/or deletions to such list to the Chairman of the Niagara County Legislature who, subject to Legislative approval, may review and modify said list as deemed appropriate

2. Disclosure of interest in County business

To the extent that he or she knows thereof, a member of the Legislature and any public officer or employee of the County of Niagara who participates in the discussion or gives official opinion to the Legislature, or any other officer or employee, on any matter before the Legislature, shall disclose the nature and extent of any direct or indirect financial or other private interest he or she has in such matter in a concise written statement to the Chairman of the Legislature, who shall direct such statement to be printed in the official record of the proceedings of the Legislature.

3. Disclosure and abstention in proceedings of County Legislature

When a member of the Niagara County Legislature must take official action on a manner in which he or she has a personal or economic interest distinct from that of the general community, their constituents, or a substantial class of the general community or their constituents, the Legislator should consider divesting that interest, if it can be feasibly done without undue hardship. The Legislator's decision in that regard shall be conclusive. If the Legislator does not divest that interest, considering both the seriousness of any appearance of impropriety and the seriousness of the public's need for participation in the action under consideration, the Legislator must abstain from participation in such action.

4. Maintenance of disclosure statements

Transactional disclosure statements filed pursuant to this Code of Ethics and annual statements shall be sealed, indexed and maintained on file for five (5) years, in an appropriate manner, by the Board of Ethics.

Such Disclosure Statements shall be destroyed upon the expiration of this five (5) year period. Such Disclosure Statements filed in 2019, and all subsequent years, by those individual listed in section 2 above, shall be made available to the public upon proper written request pursuant to the disclosure requirements of the New York State Freedom of Information Law (FOIL).

5. Failure to file disclosure statements

In addition to the filing requirements set forth in Section 2, subdivision 1 herein, each person who is subject to the filing requirements of this Code of Ethics shall file his or her Disclosure Statement on or before May 15th of each year.

Upon failure to file a Disclosure Statement, the Board shall notify the reporting person in writing, state the failure to file, and provide the person with a fifteen (15) day period to cure the deficiency. If the person fails to make such filing or fails to cure the deficiency within the specified time period, the Board shall send a notice of delinquency to: (a) the reporting person; (b) the Chairman of the Legislature. The Chairman of the Legislature shall cause the list of those persons who have failed to file reporting statements to be published in the Minutes of the Niagara County Legislature. Any person who fails to file shall be subject to the appropriate sanctions as set forth in Section 14 of this Code of Ethics.

A person who is subject to the filing requirements of this Code of Ethics, who enters into his or her official duties after May 15th of any year, shall have thirty (30) days within which to file his or her transactional disclosure statement.

## SECTION 3. GIFTS

No County officer or employee shall, directly or indirectly, solicit any gift or accept or receive any gift, whether in the form of money, service, loan, travel, entertainment, hospitality, thing, or promise, or in any other form, under

circumstances in which it could reasonably be inferred that the gift was intended to influence that officer or employee, or could reasonably be expected to influence them, in the performance of their official duties or was intended as a reward for any official action. In the absence of clear and convincing evidence to the contrary, it shall be presumed that any gift of less than $75.00 in value is not violative of this section.

## SECTION 4. OUTSIDE EMPLOYMENT

No County officer or employee shall engage in any outside employment which, under State Law, would be in conflict with or incompatible with his or her official duties with the County.

## SECTION 5. REIMBURSEMENT FOR TRAVEL EXPENSES

A County officer or employee may accept reimbursement for travel expenses from the federal government, the State of New York, other municipal government entities, nongovernmental agencies, or individuals for travel related to the officer or employee's official County duties under the following conditions:

1. The officer or employee files a written request with the appropriate department head within a reasonable period of time in advance of the event or activity for approval to receive travel reimbursement in accordance with these rules;
2. The appearance, presence, or participation of the officer or employee is for a County agency purpose and would benefit the County agency involved; or the appearance, presence, or participation of the officer or employee is at a meeting, seminar, or conference of a not-for- profit professional organization and will result in increased knowledge in the officer or employee's subject matter area which would benefit the agency involved;
3. The department head approves such travel reimbursement pursuant to these rules or, if the person travelling is a department head, then such travel shall be approved by the Chairman of the appropriate Legislative committee;
4. The travel expenses, if not reimbursed, could be paid by the County agency according to its travel reimbursement procedure;
5. The expenses reimbursed on behalf of the officer or employee would be at a rate not materially greater than the County agency would reimburse the officer or employee under its travel rules or regulations;
6. The reimbursed expenses for food and lodging at the site to which the travel occurs is provided for no longer than the officer or employee is reasonably required to be present at such event and is only for such officer or employee;
7. The reimbursed expenses are not received from or on behalf of an individual who, or on behalf of an organization, or any of its officers or members of the board of directors, other than any governmental entity, which:
    a. Is regulated by, regularly negotiates with, appears before on other than a ministerial matter, does business with, or has contacts with either the County agency employing the officer or employee or the officer or employee in his or her official capacity on behalf of the County agency; or
    b. Attempts to lobby or to influence action or positions on Legislation before either the County agency employing the officer or employee or the officer or employee in his or her official capacity on behalf of the County agency; or
    c. Is involved in litigation, adverse to the County, with the County agency with which the officer or employee is employed or affiliated, or the officer or employee in his or her official capacity, and no final order has been issued; or
    d. Has received or applied for funds from the County agency employing the officer or employee at any time during the previous calendar year, up to and including the date of the proposed travel.
8. Any reimbursement for travel expenses for each trip which totals in excess of $1,000 received by an officer or employee required to file a financial disclosure statement pursuant to this Code of Ethics must be reported in that disclosure statement, regardless of whether approval for such receipt is required under these rules.
9. Nothing herein shall preclude the use of either County vehicles (or other transportation) or personnel where such have been specifically assigned for use to any officer or employee and such use is authorized or provided to such official, officer, or employee as part of his or her employment or for his or her security.
10. Under no circumstances shall an officer or employee submit for or receive reimbursement for the same travel expenses from more than one agency, organization, or governmental entity.

## SECTION 6. REPRESENTATION BEFORE COUNTY AGENCIES AND COURTS

1. One's own agency. No officer or employee shall, at any time, represent any private interest before one's own agency or department.
2. Before other agencies or departments for a fee. No officer or employee shall receive or enter into any agreement, express or implied, for compensation for services to be rendered in relation to any matter before any County agency or department, except as otherwise permitted by law.
3. Courts. No officer or employee shall represent private interests in any action or proceeding against the interest of the County in any litigation to which the County is a party. If said officer or employee is an attorney, such attorney should not engage in activities before courts, County agencies, or departments in which the attorney's personal or professional interests are, or foreseeably may be, in conflict with their official duties.

## SECTION 7. FUTURE EMPLOYMENT

After the termination of service or employment with the County or its agencies, no County officer or employee shall appear or practice before any board or agency of the County of Niagara, except on his or her own behalf, for a period of one (1) year after the termination of his or her service or employment. In relation to any case, proceeding, or application in which that person personally participated during the period of service or employment, or which was under the person's active consideration, the prohibition against any such appearance or practice shall be permanent.

## SECTION 8. USE OF POSITION

1. Any person whose position is subject to appointment by the Legislature and/or Chairman be prohibited from holding an executive office in any political party organization nor shall an executive officer of any political party contract with the County to provide services or products. An executive office is defined as Chairman, Vice-Chairman, Treasurer, and Secretary.
2. No County officer or employee shall accept any employment or acquire any investment under circumstances in which an impression may reasonably be created that that person will thereby be influenced in the conduct of their office, but nothing contained herein shall prohibit any officer or employee from holding any position of employment with any other governmental body or authority not otherwise incompatible with State Law. No County officer or employee shall use or attempt to use their official position (i) to secure unwarranted benefits, privileges or exemptions for themselves or others and/or (ii) to coerce or induce another person to provide any benefit, financial or otherwise, to him/herself or to friends, relatives, or persons with whom the employee is affiliated in a governmental or nongovernmental capacity.
3. No County officer or employee shall take or refrain from taking any action on any matter before the County in order to obtain a pecuniary or material benefit for: (1) himself or herself; (2) a family member; (3) any partnership or unincorporated association of which the County officer or employee is a member or employee or in which he or she has a proprietary interest; (4) any corporation of which the County officer or employee is an officer or director or of which he or she legally or beneficially owns or controls more than 5% of the outstanding stock; (5) any person with whom the County officer or employee or his or her family member has an employment, professional, business, or financial relationship; or (6) any person from whom the County officer or employee, or his or her spouse, has received a pecuniary or material benefit having an aggregate value greater than $1,000 per year.
4. No County officer or employee who, or whose spouse, owns or controls 5% or more stock in a firm and no partnership or unincorporated association as defined in Subsection 3 above may do business with the County unless:
    a. The value of the goods or services does not exceed $500 per year; or
    b. The goods or services are provided after public notice and competitive bidding; or
    c. The goods or services consist of rental property so long as the County officer or employee is not employed by the department or agency that is providing funds for the rental, tenancy, or shelter.
5. No County officer or employee shall directly or indirectly compel any non-elected officer or employee of the County to participate in an election campaign, or compel the payment of any assessment, subscription, or contribution to a political party, political party organization, election campaign, or candidate, nor shall such County officer or employee circulate political petitions during working hours on County property. No political solicitation for funds shall take place at any time on County property. No County property or equipment shall be used in connection with any election campaign or to aid any political party, political party organization, election campaign, or candidate. This

paragraph shall not prohibit a general solicitation of a class of persons, other than those expressly prohibited, of which such solicited officer or employee happens to be a member. Notwithstanding the foregoing, the County buildings (after normal working hours) and County recreational facilities may be available to a political party organization or election campaigns for political activities, meetings and functions.

6. County officers or employees shall not take or refrain from taking any action on any matter before the County which gives the impression of favoritism in their official duties, and which is based on kinship, rank, position, or influence.
7. Nothing in this section shall be construed to prohibit a County officer or employee or any other person from receiving a County service or benefit or using a County facility, which is generally available to residents or a class of residents in theCounty.
8. No County officers or employee shall use public resources that are not available to the public in general, such as County staff time, equipment, supplies or facilities, for private gain or personal purposes. Private gain or personal purpose shall be defined as that in which the personal benefit outweighs any public interest and shall include any County resource use for the benefit of friends, relatives or persons with whom the County officer or employee is affiliated in a governmental or nongovernmental capacity.

## SECTION 9. DUTY TO REPORT

Every County officer or employee shall have an affirmative duty to report promptly to the District Attorney and the County Attorney any action which may reasonably be interpreted as an improper attempt to influence them in the conduct of their office. Every County officer or employee shall have an affirmative duty to report promptly to the Board of Ethics any action which the officer or employee reasonably interprets to be a violation of this Code ofEthics.

County officers and employees shall be protected against reprisal for the lawful disclosure of information which the officer or employee reasonably believes to be a violation of this Code ofEthics.

## SECTION 10. DISCLOSURE OF INFORMATION

No County officer or employee shall, except where authorized by law, disclose any information for personal gain or to advance the financial interests of any other person or entity.

## SECTION 11. NIAGARA COUNTY BOARD OF ETHICS COMPOSITION

1. The Niagara County Board of Ethics, heretofore created by Resolution of the Niagara County Legislature adopted September 15, 1970 is terminated effective December 31, 1995, subject to the provisions of this Section.
2. The Niagara County Board of Ethics shall consist of five (5) members, to be appointed by the Chairman of the Niagara County Legislature, subject to confirmation by the County Legislature by a simple majority, who shall serve for three (3) year terms of office. Of the five (5) members first appointed, two (2) shall serve for one year, two (2) shall serve for two (2) years, and one (1) shall serve for three (3) years, as designated by the Chairman. In the event of a vacancy prior to the expiration of the three (3) year term of office of any member, a successor shall be appointed by the Chairman within sixty (60) days of the occurrence of the vacancy, for the balance of the term. As vacancies occur, successor members shall be appointed by the Chairman of the Legislature subject to confirmation by the County Legislature by a simple majority. A person appointed to fill a vacancy occurring other than by expiration of a term of office shall be appointed for the unexpired term of the member he or she succeeds.
3. There shall be no more than three (3) members of the same political party serving on the Board at any one time. A majority of the members shall be persons other than County officers or employees but at least one (1) member shall be a County officer or employee. All members shall reside in Niagara County. All members shall serve without compensation, but shall be entitled to reimbursement for reasonable expenses and for mileage in accordance with those rules established by the Legislature.
4. The Chairman of the Legislature shall appoint a Chairman of the Board of Ethics from among its members. Three (3) members of the Board shall constitute a quorum and the Board shall have the power to act by majority vote of the members of the Board present. The County Attorney, or one of his assistants, shall serve as legal counsel to the Board.
5. In addition to the sanctions set forth in Section 14 of this Code of Ethics for violation of said Code, and other

pertinent sections of local and state law, any member of the Board of Ethics may be removed from office prior to the expiration of their term of office by resolution of the County Legislature by a simple majority.

6. Failure on the part of any member of the Board of Ethics to attend three (3) consecutive meetings of the Board, without good cause shown to the Chairman of the Board, shall be grounds for immediate removal.

## SECTION 12. POWERS, DUTIES, AND FUNCTIONS OF THE BOARD OF ETHICS

The Board shall have the powers, duties, and functions provided by Article 18 of the General Municipal Law including, but not limited to:

1. The Board of Ethics shall be the repository for completed annual Disclosure Statements and such other written instruments, affidavits, and disclosures as required by law. The Board shall inspect all Disclosure Statements to ascertain whether any person required to file a statement has failed to do so, has filed a deficient statement, or has filed a statement which reveals a possible violation of this Code.
2. The Board of Ethics shall possess, exercise, and enjoy all the rights, powers, and privileges necessary to the enforcement of this Code of Ethics, and shall, in all respects, be considered to be an agency of the County.
3. The Board of Ethics shall promulgate rules and regulations in furtherance of its power and duties, including rules governing the conduct of adjudicatory proceedings and appeals therefrom, relating to the assessment of the civil sanctions as set forth in Section 14 of this Code.
4. The Board of Ethics shall periodically review, update, publish, and circulate a "Question and Answer" handbook that discusses common ethical issues that arise under this Code.
5. In the appropriate case, the County Legislature may, by resolution, following a written request from the Chairman of the Board of Ethics, empower the Board to subpoena any individual, whether or not a County officer or employee, or any document or thing deemed necessary to the Board in resolving any pending adjudicatory proceeding or investigation. The County Legislature shall act in a manner so that the subject matter of the request, the person, and the department involved shall not be a matter of public disclosure.
6. The Board of Ethics shall render advisory opinions, in writing, to County officers and employees upon written request of the officer or employee with regard to his or her own affairs. The head of a County department, administrative unit, or other agency may request an advisory opinion with regard to the affairs of any of his or her subordinates.

   The District Attorney, County Attorney, Sheriff, County Auditor, Chairman of the Legislature, or Majority Leader or Minority Leader of the Legislature may request an advisory opinion with regard to the affairs of any County officer or employee.
7. Said advisory opinions shall be rendered, if practicable, within thirty (30) days of the written request. The thirty (30) day time period may be extended by an additional thirty (30) days at the Board's discretion.
8. Thereafter, if deemed necessary by the Board, the time period may be extended by an additional ninety (90) days upon notification to the Clerk of the Legislature that a particular matter is under investigation and an additional ninety (90) days is required. The Clerk of the Legislature shall cause such notification of extension to be published in the minutes of the Niagara County Legislature without publicly disclosing the subject of the investigation, the person, or the department involved. In any event, the Board shall render its advisory opinion no later than one hundred fifty (150) days from the date of receipt of the written request.
9. Said advisory opinions shall not be made public or disclosed unless required by the Freedom of Information Law (Public Officers Law Article 6) or pursuant to Judicial subpoena or required to be used in a disciplinary proceeding or a proceeding under Section 14 of this Code involving the County officer or employee who requested the opinion. Whenever a request for access to an advisory opinion is received, the County officer or employee who originally requested the advisory opinion shall be notified of the subsequent request for access within three (3) business days of its receipt.
10. All citizens of the County of Niagara may, in writing, notify the Board of Ethics of any perceived violations of the Code of Ethics. The Board shall review said citizen complaints and make an initial determination of whether or not an advisory opinion is appropriate. This determination shall be made by a simple majority of those members of the Board present.
11. If it is determined by the Board that an advisory opinion will be rendered upon citizen complaint, the Board shall act upon such complaint following the procedures and within the time frame set forth in paragraph 6.

12. Copies of the advisory opinions rendered pursuant to a citizen's complaint shall be directed to the District Attorney and the County Attorney. In addition, if any advisory opinion is rendered, written acknowledgement of any investigation and subsequent finding shall be directed to the citizen complainant. For purposes of this Code of Ethics, "citizens of the County of Niagara" shall include persons who reside in, are employed within, or own real property in Niagara County.
13. In the event that the Board of Ethics fails to act, or acts in contravention of the Code of Ethics, an aggrieved party may pursue any remedies available, in law or in equity, including, but not limited to, a proceeding under Article 78 of the Civil Practice Law and Rules.
14. Such advisory opinions shall be in writing and shall discuss, at minimum, the issue the Board is presented with, a summary of the evidence or information upon which the Board is basing its decision, the response, if any, from the person whose conduct is questioned, and the decision of the Board, including recommendations for sanction under Section 14 of this Code, referrals to other government agencies, or conclusions that no further action is necessary.
15. The Board may make such additional rules and regulations as it shall consider appropriate in relation to its procedures.
16. The Board of Ethics shall be empowered to request support staff assistance from the Chairman of the Legislature or the Director of Human Resources, as necessary, in furtherance of its duties and responsibilities.
17. The Board of Ethics shall meet, at a minimum, on a quarterly basis, and at any other time or times deemed necessary by the Chairman of the Board to responsibly fulfill its duties to the citizens of the County of Niagara.

## SECTION 13. COMPILATION AND DISTRIBUTION OF THIS CODE

The Director of Human Resources shall cause a copy of this Code to be distributed to every officer and employee of the County within sixty (60) days after the effective date of this Local Law or as soon thereafter as may be practicable. Every officer and employee elected or appointed thereafter shall be furnished with a copy of such Code within ten (10) days after entering upon the duties of their office or employment. A "Question and Answer" handbook shall be prepared and circulated. The Board of Ethics shall periodically review and update the "Question and Answer" handbook that discusses common ethical questions arising under this Code. This periodic review should be undertaken at least once every two (2) years.

## SECTION 14. COMPLAINTS AND HEARINGS

1. All complaints alleging a violation of this code must be submitted in writing. The complainant must sign his or her name and state his or her address.
2. The identity of the complainant and the nature of the complaint shall be kept confidential whenever reasonably possible.
3. Upon receipt of a complaint, the Board shall make a determination as to whether, on its face, the complaint alleges a violation of the Code of Ethics. If a determination is made that a violation is not alleged by the complaint, the Board shall notify the complainant of its determination in writing.
4. If a determination is made that a violation is alleged by the complaint, the Board shall notify, in writing, the person against whom the complaint is made of the nature of the complaint and the Code provisions allegedly violated. The Board shall also notify the complainant that the complaint has been received and shall be reviewed by the Board.
5. The person charged with a violation shall have fifteen days from receipt of notice of the violation to respond in writing to the Board's notice of alleged violation. The response shall either admit the violation or state facts supporting a denial of the charge.
6. If the charge is denied, the Board shall either dismiss the charge if the facts presented so warrant or conduct a fact hearing.
7. A fact hearing shall consist of sworn testimony, affidavits or such documentary evidence as the Board allows. The person charged shall be allowed to present evidence and to confront evidence presented against him or her. The person charged may be represented by legal counsel. Strict rules of evidence under the laws of the State of New York shall not apply to the hearing. The Board may direct that the hearing be stenographically recorded and transcribed.
8. After the hearing is concluded, the Board shall issue its decision in writing, indicating the reasons therefor. Such decision shall be rendered, if practicable, within the time limits set forth for advisory opinions as contained in Section 12 herein.

## SECTION 15. SANCTIONS

1. Disciplinary Action
   Any County officer or employee who engages in any action that violates any provision of this Code may be warned or reprimanded or suspended or removed from office or employment, except as otherwise provided by the Public Officers Law of the State of New York, or be subject to any other sanction authorized by law or collective bargaining agreement by the appointing authority or person or body authorized by law to impose such sanctions. No provision herein shall bar a county officer or employee from pursuing any and all rights afforded to them under any collective bargaining agreement to which they are a party should the Board of Ethics recommend oral warning, written reprimand, suspension from employment with or without pay, or removal from office as a result of the officer or employee having been found to have engaged in any action that violates any provision of this Code. An oral warning, written reprimand, suspension from employment with or without pay, removal from office or employment, or other authorized sanction may be imposed in addition to any other penalty contained in this Code or in any other provision of law.
   Any sanctions prescribed by this code relative to employees shall be subject to the terms and procedures outlined in the respective Collective Bargaining Agreements and shall not supersede the terms of the properly executed Collective Bargaining Agreements.
2. Civil fine
   Any County officer or employee who violates any provision of this Code may be subject to a civil fine of up to $1,500 for each violation. A civil fine may be imposed in addition to any other penalty contained in any other provision of law or in this Code, other than a civil forfeiture, pursuant to Subdivision 4 of this section.
3. Damages
   Any person, whether or not a County officer or employee, who violates any provision of this Code shall be liable in damages to the County for any losses or increased costs incurred by the County as a result of the violation. Such damages may be imposed in addition to any other penalty contained in any other provision of law or in this Code, other than a civil forfeiture, pursuant to Subdivision 4 of this section.
4. Civil forfeiture
   Any person, whether or not a County officer or employee, who intentionally or knowingly violates any provision of this Code, may be subject to a civil forfeiture to the County in a sum equal to three times the value of any financial benefit he or she received as a result of the conduct that constituted the violation. A civil forfeiture shall be imposed in addition to any other penalty contained in any other provision of law or in this Code, other than a civil fine pursuant to Subdivision 2 or damages pursuant to Subdivision 3 of this section.
5. Violation
   Any person, whether or not a County officer or employee, who intentionally and knowingly violates any provision of this Code shall be guilty of a violation and, upon conviction thereof, if a County officer or employee, shall forfeit his or her County office or employment, subject to the procedures in Civil Service Law and the respective Collective Bargaining Agreements.
   Any person, whether or not a County officer or employee, who intentionally and knowingly solicits, requests, commands, importunes, or aids a person to violate any provision of this Code shall be guilty of a violation and, upon conviction thereof, if a County officer or employee, shall forfeit his or her County office or employment, subject to the procedures outlined in Civil Service Law and the respective Collective Bargaining Agreements.
6. Debarment
   a. Any person, whether or not a County officer or employee, who intentionally or knowingly violates any provision of this Code, shall be prohibited from entering into any contract with the County for a period not to exceed 25 years. The term of such prohibition shall be established by the Board of Ethics after notice and hearing as set forth herein.
   b. No person, whether or not a County officer or employee, shall enter into a contract in violation of a bar imposed pursuant to Subdivision a of this subsection.
   c. Nothing in this subsection shall be construed to prohibit any person from receiving a service or benefit or from using a facility, which is generally available to the public.
   d. Under this subsection, a corporation, partnership, or other entity shall not be held vicariously liable for the

actions of an employee. A corporation, partnership, or other entity shall not be debarred because of the actions of an employee unless the employee acted in the execution of company policy, request, or custom. A store, region, division, or other unit of an entity shall not be debarred because of the actions of an employee of that unit unless the employee acted at the direction, or with the actual knowledge or approval, of the manager of the unit.

7. Whenever any provision of this Code is in conflict with any article of a valid collective bargaining agreement between Niagara County and any of its recognized unions or in conflict with any provisions of the Civil Service Law of the State of New York or the Penal Law, the provisions of the respective collective bargaining agreements or the Civil Service and Penal Laws shall be in full force and effect and shall supersede the provisions of this Code.

## SECTION 16. ENFORCEMENT OF SANCTIONS

The Board of Ethics shall make recommendations for oral warnings or written reprimands. It shall utilize the Human Resources Department, the Payroll Department, the Civil Service Commission, or any other appropriate County agency or department to see to it that warnings, reprimands, suspensions, or removals from office are effectuated. It shall utilize the County Attorney's Office to see to it that civil fines, damages, civil penalties, and debarments are executed. It shall refer activity that could constitute a criminal violation to the Niagara County Sheriff and the District Attorney's Office. The Board of Ethics shall also file copies of its opinions and determinations with the County Clerk. Whether such opinions, determinations, and proceedings are subject to public disclosure shall be governed by the State Freedom of Information Law.

## SECTION 17. INJUNCTIVE RELIEF

1. Any citizen of the County, or officer or employee of the County may initiate an action or special proceeding, as appropriate, in a court of appropriate jurisdiction for injunctive relief to enjoin an officer or employee of the County from violating this Code or to compel an officer or employee of the County to comply with the provisions of this Code. In lieu of, or in addition to, injunctive relief, the action or special proceeding, as appropriate, may seek a declaratory judgement.
2. No action or special proceeding shall be prosecuted or maintained pursuant to Subdivision 1 of this section, unless (a) the plaintiff or petitioner shall have filed with the Board of Ethics a written complaint alleging the violation by the officer or employee, (b) it shall appear by and as an allegation in the complaint or petition filed with the court that at least one hundred fifty (150) days have elapsed since the filing of the complaint with the Board of Ethics, and that the Board has failed to file a determination in the matter, and (c) the action or special proceeding shall be commenced within ten (10) months after the alleged violation occurred. If the violation is a continuing one, action must occur within ten (10) months of discovery of the alleged violation.

## SECTION 18. SEVERABILITY OF CODE PROVISIONS

If any provision of this Local Law or application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Local Law which can be given effect without the invalid provision or application and to this end the provisions of this Local Law are declared severable.

## SECTION 19. EFFECTIVE DATE

This Local Law shall take effect upon filing with the New York State Secretary of State, after which it shall become a law.

## RESOLUTIONS AMENDING CODE OF ETHICS:

Resolution No. AD-0005-96 Resolution No. IL-0048-96 Resolution No. AD-024-97 Resolution No. IL-002-98 Resolution No. AD-026-98 Resolution No. AD-006-01 Resolution No. IL-053-07 Resolution No. AD-009-19

**Attachment 4 Compliance Complaint Form**

**NIAGARA COUNTY DEPARTMENT OF HEALTH**

# COMPLIANCE COMPLAINT

**Reporter (if known)** _____ **Date** _____

**Received by** _____

**COMPLAINT:**

**DOCUMENTATION OF INVESTIGATION: (SIGNATURE AND DATE WITH ALL ENTRIES)**

**STATEMENT OF RESOLUTION:**

**Signature** _____ **Date** _____

## Attachment 5 Medicaid Fraud Poster

NEW YORK STATE OF OPPORTUNITY. Office of the Medicaid Inspector General

# BLOW THE WHISTLE

# ON MEDICAID FRAUD

**Report Medicaid fraud, waste or abuse to the Office of the Medicaid Inspector General**

**Toll Free: 877-87-FRAUD**

**877-873-7283**

**Medicaid fraud is not a victimless crime and can occur along with waste and abuse in many different ways. Below are some examples of Medicaid fraud, waste, and abuse.**

| | |
|---|---|
| **Medical Identity Theft** | Using another person's medical information to obtain money, items, or services. |
| **Upcoding/Unbundling** | Billing for services at a level of complexity that is higher than the service actually provided or documented, or using multiple codes for services covered by a single code. |
| **Services or Supplies Not Rendered** | Billing for services or supplies not provided to a beneficiary, services not documented correctly, or both. |
| **Kickbacks** | Soliciting or receiving remuneration (in kind or in cash) in return for referring individuals, goods, or services that may be paid under the Medicaid program. |
| **Excluded Individuals** | Employing or contracting with any excluded individual or entity for the provision of items or services that are reimbursable, directly or indirectly, by any Federal health care and/or State Medicaid program. |
| **Drug Diversion** | Illegally prescribing, distributing, abusing, or overusing prescription drugs. |
| **Beneficiary Fraud** | Eligibility fraud, card sharing, doctor shopping, and drug diversion. |
| **Quality of Care/ Patient Abuse/ Neglect** | Abusing, neglecting, or exploiting Medicaid patients, including committing physical and mental abuse, withholding medically necessary services, or neglecting to provide appropriate or adequate care. |
| **General Fraud and Abuse** | Billing in ways inconsistent with sound financial management or professional standards; or payment/billing is fraudulent when done intentionally and abusive if unintentional. |
| **Waste** | Over utilizing Medicaid benefits, such as prescribing inappropriate or unnecessary drugs, medical equipment and supplies, or medical services. |

**If you suspect fraud or abuse, contact the Office of the Medicaid Inspector General**

www.omig.ny.gov

Facebook and Twitter @nysomig

877-87-FRAUD / 877-873-7283

www.omig.ny.gov/medicaid-fraud/file-allegation

Updated September 2021

## Attachment 6 Fraud Allegations Form


Kathy Hochul, Governor — Frank T. Walsh, Jr., Acting Medicaid Inspector General

New York State Office of the Medicaid Inspector General - Bureau of Medicaid Fraud Allegations (BMFA)
800 North Pearl Street, Albany, NY 12204
Email: BMFA@omig.ny.gov Phone: 877-873-7283 FAX: 518-408-0480

Allegation Date: _____

**YOUR INFORMATION:** ***I would like to be considered:***

☐ CONFIDENTIAL (Your information is kept private, but your identity is known to OMIG. This allows OMIG to contact you to obtain additional information or clarify your allegation.)

☐ ANONYMOUS (no personal information is provided/known to OMIG-BMFA)

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Email: _____ MEDICAID ID#: _____

**THE ALLEGATION IS AGAINST :** ☐ Provider ☐ MEDICAID Recipient

Name: _____ Provider ID/License# *or* MEDICAID ID# _____

Address: _____ City: _____ State: _____ ZIP: _____

County: _____ DOB: _____ SS# _____

Phone: ( ) _____ Email: _____

**ALLEGATION:** _____

FIGHTING FRAUD ○ IMPROVING INTEGRITY AND QUALITY ○ SAVING TAXPAYER DOLLARS

Updated September 2021

## Attachment 7 Qui Tam Law and other State and Federal Compliance Laws

**qui tam action**

: (kwee tam) n. from Latin for "who as well," a lawsuit brought by a private citizen (popularly called a "whistle blower") against a person or company who is believed to have violated the law in the performance of a contract with the government or in violation of a government regulation, when there is a statute which provides for a penalty for such violations. Qui tam suits are brought for "the government as well as the plaintiff." In a qui tam action the plaintiff (the person bringing the suit) will be entitled to a percentage of the recovery of the penalty (which may include large amounts for breach of contract) as a reward for exposing the wrongdoing and recovering funds for the government. Sometimes the federal or state government will intervene and become a party to the suit in order to guarantee success and be part of any negotiations and conduct of the case. This type of action is generally based on significant violations which involve fraudulent or criminal acts, and not technical violations and/or errors.

The People's Law Dictionary by Gerald and Kathleen Hill Publisher Fine Communications

There are a number of laws on both the State and Federal level which impact Compliance issues. Below is a description of some of these laws and the brief description of their relation toCompliance issues.

**Anti-Kickback Statutes**

There are several federal and state anti-kickback statutes which focus upon "knowingly and willingly solicits or receives any remuneration (including a kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in-kind : A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which paymentmay be made in whole or in part under a federal healthcare program, or B) in return for purchasing, leasing, ordering or arranging for or recommending purchasing , leasing, or orderingof any good, facility , service or item for which payment may be made in whole or in part under a federal health care program" (Social Security Act §1128B(b); 42 USC §1320a-7b(b)).

The Medicare and Medicaid Patient and Program Protection Act, 42 USC §1320a-7b(b), asamended (the "Anti-Kickback Statute") prohibits:

- The knowing and willful offer or receipt of any remuneration (defined broadly to include anything of value) in exchange for a referral or which is intended to induce a referral for thefurnishing or arranging for the furnishing of any item or service for which payment may be made under a federal health program, including the Medicare and Medicaid programs.
- The offer or receipt of remuneration in exchange for or which is intended to induce the purchase, lease, order or arranging for or recommending the purchase, lease or order of any good, facility, service or item for which payment may be made under a federal healthcare program, including Medicare and Medicaid.

**The Stark Laws**

The Stark Laws are a set of federal laws that attempt to control the amount of remuneration from facilities and services a physician can receive if that same physician has a financial interestin the facilities/services. In terms of these laws, the word "physician" is interpreted to mean osteopathic physicians, dentists, optometrists, and chiropractors, to name a few specialties.

The physician self-referral provisions contained in 42 USC §1395nn (Commonly referred to as the "Stark Law") prohibit a physician with a financial relationship with an entity from making a referral to that entity for the furnishing of certain "designated health services" for which paymentmay be made under Medicare or Medicaid.

**The False Claims Act**

The federal False Claims Act is one of the driving forces behind the requirement for Compliance Plans. This law delineates both civil and criminal penalties for the filing of false claims. This Act is not limited in application to the health care field. Congress originally passed some of these laws in the nineteenth century. The current focus upon provisions of this act being interpreted in the health care arena is consistent with the manner in which this law has been applied to other industries.

The False Claims Act imposes civil liability on any person or entity that submits a false or fraudulent claim for payment to the United States government. The False Claim Act coversfraud involving any federally funded program, with the exception of tax fraud. The primary activities that constitute violations under the False Claims Act include:

- Knowingly presenting (or causing to be presented) to the Federal Government a false orfraudulent claim for payment;
- Knowingly using (or causing to be used) a false record or statement to get a claim paid bythe federal government;
- Conspiring with others to get a false or fraudulent claim paid by the Federal Government;and
- Knowingly using (or causing to be used) a false record or statement to conceal, avoid, ordecrease an obligation to pay money or transmit property to the Federal Government.
- The "qui tam" or "whistleblower" provision of the False Claims Act (FCA) allow an individual who knows about a person or entity who is submitting false claims to bring suit, on behalf ofthe government, and to share in the damages recovered as a result of the suit (FCA§3730(b)).

***Antitrust Laws***

Creating a trade monopoly, unfair methods of competition and other means that limit competition may not be legal and may be governed by federal and/or state antitrust laws and regulations. Certain types of joint ventures involving the acquisition of equipment, group purchasing agreements and transactions that tend to monopolize a market for particular types ofservices might trigger an antitrust review.

It is the policy of Niagara County Department of Health Nursing Division to comply fully withfederal and state antitrust laws and regulations.

Employees of Niagara County Department of Health Nursing Division may not enter into agreements or understandings with a competitor that unlawfully limit or restrict competition.

This policy applies not only to express formal and written agreements but also to imply informaland oral agreements.

When purchasing goods or services for Niagara County Department of Health Nursing Division,employees may not enter into agreements or understandings that unlawfully limit or restrict purchasing decisions of Niagara County Department of Health Nursing Division.

For example, no employee of Niagara County Department of Health Nursing Division may agreewith other health care systems or providers to boycott a given supplier or to pay no more than a given amount for some good or service.

***Laws relating to tax exempt status***

It is the policy of Niagara County Department of Health Nursing Division to comply fully with all federal and state laws and regulations and to preserve the tax-exempt status of Niagara CountyDepartment of Health Nursing Division.

Niagara County Department of Health Nursing Division will conduct its operations in such a manner as to enable the resources of Niagara County Department of Health Nursing Division to be used for the benefit of the community, rather than the private interests of any individual withinNiagara County Department of Health Nursing Division.

Niagara County Department of Health Nursing Division and its employees will avoid compensation arrangements or other transactions in excess of fair market value that might jeopardize the tax-exempt status of Niagara County Department of Health Nursing Division.

All tax information and tax returns will be filed in accordance with applicable law.

***Penalty for violations***

A violation of these laws may result in significant criminal and civil penalties, including substantial monetary penalties and possible exclusion from participation in a federal health careprogram.

**A Brief Summary of the Stark Law and Anti-Kickback Statute Reforms (Final Rules)Background**

On December 2, 2020, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) published the final rule, "Revisions to the Safe Harbors Under the Anti-Kickback Statute (AKS) and Civil Monetary Penalty (CMP) Rules Regarding Beneficiary Inducements," and the Centers for Medicare and Medicaid Services (CMS) published the final rule, "Modernizing and Clarifying the Physician Self-Referral Regulations" in the *Federal Register.*[1] These rules are part of the HHS Regulatory Sprint to Coordinated Care, which examined federal regulations that potentially impede healthcare providers' efforts to advance the transition to value-based care and improve the coordination of patient care across care settings in federal health care programs and the commercial sector.

The AMA submitted comments on both the AKS proposed rule and the Stark Law proposed rule in December 2019.

Effective Dates: The Stark and AKS final rules give an effective date of January 19, 2021, for most of the provisions, with the exception of certain changes to the definition of a "group practice," which have an effective date of January 1, 2022, to give physician practices additional time to adjust their compensation methodologies.[2]• [3]

_____

NOTE: There are fundamental differences in the statutory structure, operation, and penalties between theStark Law and the AKS and, as a result, complete alignment between the exceptions to the Stark Law and safe harbors to the AKS is not feasible. The differences between the two final rules create a dual regulatory environment, where a value-based arrangement could meet the requirements for protection under one law but not the other, which could hinder the transition to a value-based health care delivery and payment system. In the final rule, CMS acknowledged the "dual regulatory environment" and the challenges for stakeholders in ensuring compliance with both. **If, upon reviewing this information, a reader wishes to pursue any of the opportunities and/or options described herein, the AMA strongly recommends consultation with health care counsel experienced in the federal Stark Law and the AKS, as well as the applicable state's fraud and abuse laws, prior to taking any actions in reliance on the final rules discussed in this brief summary.**

[1] The Medicare physician self-referral law (often called the "Stark Law"), has not been significantly updated since it was enacted in 1989. When the Stark Law was enacted in 1989, healthcare was paid for primarily on a fee-for- service basis. Since that time, Medicare and the private market have implemented many value-based healthcare delivery and payment systems to address substantial cost growth in the current volume-based system.

[2] Note: The Congressional Review Act (CRA) is an oversight tool that Congress may use to overturn
Rules issued by federal agencies. As of January 9, 2020, the CRA had been used to overturn a total of 17 rules. Sixteen of those rules were overturned in the 15th Congress (2017-2018). Prior to the 115th Congress, one rulewas overturned in the 107th Congress (2001-2002). https://fas.org/sgp/crs/misc/R43992.pdf

[3] The official scheduled publication date of these rules is listed as December 2, 2020, which creates doubt under the CRA about whether the rules can go into effect prior to President-elect Biden's inauguration on January 20, 2021. Under the CRA, the 60-day clock begins to tick upon the date of publication in the *Federal Register,* not the informal public display of a final rule. New administrations may institute a hold on any regulation that has not gone into effect by inauguration day or shortly thereafter in order to have time to review those regulations. The AMA will**continue to monitor this issue.**

**The Physician Self-Referral Law Changes**

The final rule creates new, permanent exceptions to the Stark Law for value-based arrangements. Theexceptions apply regardless of whether the arrangement relates to care provided to Medicare or other patients.

**Definitions**

*Target Patient Population:* In the proposed rule, CMS sought public comment on whether it should incorporate a requirement that patients in the target patient population have at least one chronic condition in order to align with OIG's proposals. In the AMA's comment letter, we voiced our opposition to CMS' proposal to limit a target patient population to patients with at least one chronic condition. **Consistent with the AMA's request, CMS is not limiting a target patient population to patients with at least one chronic condition.** As finalized, target patient population means an identified patient population selected by a value-based enterprise (VBE) or its VBE participants based on legitimate and verifiable criteria that are set out in writing in advance of the commencement of the value-based arrangement and further the value-based enterprise's value-based purpose(s).

*Designated Health Services:* **In alignment with the AMA's comments, CMS revised the definition of designated health services to exclude inpatient services paid for under prospective payment systems if furnishing those services does not increase the amount of Medicare's payment to the hospital.** In the final rule, CMS declined to expand the modified definition to outpatient hospital services.

*Physician:* CMS finalized the definition of "physician" as proposed. The revised definition aligns the regulatory definition of “physician" at 42 Code of Federal Regulations (CFR) §411.351[4] with the statutory definition of “physician" in §186l(r) of the Social Security Act[5] to ensure that there are no inconsistencies between the two. Under the statutory definition, a "physician" includes a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, adoctor of optometry, and a chiropractor, but provides for certain limitations on when such doctors are considered "physicians." CMS clarifies in the final rule that it does not believe that the definition of "physician" in the regulations should be either more limited or more expansive than the statutory definition. Therefore, CMS states, that to the extent that the statutory definition of "physician" includesdoctors other than doctors of medicine and osteopathy, those practitioners fall within the ambit of the physician self-referral law.

**New Compensation Exceptions**

*Value-Based Care Exceptions:* The final rule creates new, permanent exceptions to the Stark Law for value-based arrangements. The exceptions apply regardless of whether the arrangement relates to care furnished to people with Medicare or other patients. The new value-based exceptions largely mirror the proposed rules, with some changes favorable to physicians. **Consistent with the AMA's request, in thefull financial risk exception CMS has extended the "pre-risk" period from six months as proposed, to 12 months.** With regards

to the meaningful downside financial risk exception, the final rule requires the physician be responsible to pay or forego no less than 10 percent, rather than paying 25 percent as proposed, of the value of the remuneration the physician receives under the value-based arrangement.

*New Exception for Limited Remuneration to a Physician:* **The AMA is pleased that CMS finalized a new exception to protect compensation not exceeding an aggregate of $5,000 per calendar year (increased from $3,500 as proposed), adjusted for inflation, to a physician for the provision of items and services without the need for a signed writing and compensation that is set in advance if certain conditions are met.** The rule also permits the physician to provide the items or services in question through employees the physician hired for the purpose of performing the services, a wholly owned entity or locum tenens physicians.

*Other:* The AMA, along with several other public commenters, urged CMS to create an exception for value-based arrangements that is exclusively available to rural providers and small physician practices. Inthe final rule CMS acknowledged the challenges faced by rural providers and small physician practices but declined to create the requested exception.

*New Exception for Cybersecurity Technology and Related Services: New Exception for Cybersecurity Technology and Related Services:* **CMS finalized a new exception to protect arrangements involving the donation of certain cybersecurity technology and related services, including certain cybersecurity hardware donations.** Note, that this is separate from the electronic health records exception clarification by CMS, which in the final rule expressly permits donations of cybersecurity software and services that protect electronic health records under the EHR exception. **In response to AMA advocacy, CMS declined to limit the types of donors protected under this exception; instead, the final rule protects all donors.** This supports a broad scope of protected donors, including individualsor entities, hospitals, health plans, EHR vendors, manufacturers, and ancillary service providers. **Given the complexity of cybersecurity, donations may also include training services,** such as training a physician's staff on how to use the cybersecurity technology, how to prevent, detect, and respond to cyberthreats, and how to troubleshoot problems with the cybersecurity technology. **Physicians and their staff may also be provided access to a donor's primary technology help desk** (for example, to report cybersecurity incidents).

**Guidance and Clarifications**

*Clarifications to "Group Practice" Requirements:* CMS finalized clarifications to the regulations defining a "group practice" for purposes of the Stark Law. While the profits from all designated health services (DHS) of any component of the group that consists of at least five physicians (which may includeall physicians in the group) must be aggregated before distribution, CMS clarified that a group practice may utilize different distribution methodologies to distribute shares of the overall profits from all DHS ofeach of its components of at least five physicians, provided that the distribution to any physician is not directly related to the volume or value of the physician's referrals and the same methodology is used for all the physicians included in their component. As noted above, CMS delayed the effective date for this portion of the rule to January 1, 2022, to give physician practices additional time to adjust their compensation methodologies.

*Clarification for Electronic Health Records (EHR) Items and Services Exception:* The AMA voiced support for the concept of updating the exception to recognize the significant updates regarding information blocking but raised questions and voiced concerns regarding how such a provision would work in the EHR exception. CMS finalized many proposed changes to this exception however, CMS didnot finalize its proposal to modify the provision addressing the concept of information blocking and instead removed that provision from the exception due to the significant questions raised by commenters.

## AKS Changes

The AKS final rule finalizes many of OIO's proposals that modify existing AKS safe harbors, create newAKS safe harbors, and create a new CMP law exception.

**New AKS Safe Harbors**

*Value-Based Arrangements:* The 010 finalized three new safe harbors to protect certain payments among individuals and entities in a value-based arrangement. The three new safe harbors vary in terms of the type of remuneration that can be provided, the level of financial risk the parties assume (full financial risk, substantial downside financial risk, and no or lower risk), and the types of safeguards required to satisfy the safe harbor. Overall, the value-based safe harbors are generally narrower than the Stark exceptions. The 010 has stated that entities ineligible to use the value-based safe harbors are: pharmaceutical manufacturers, distributors, and wholesalers; pharmacy benefit managers (PBMs); laboratory companies; pharmacies that primarily compound drugs or primarily dispense compounded drugs; manufacturers of devices or medical supplies; entities or individuals that sell or rent durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) (other than a pharmacy or a physician,provider, or other entity that primarily furnishes services); and medical device distributors and wholesalers. However, the 010 carved out a separate, limited pathway for certain medical device manufacturers and durable medical equipment companies to participate in protected care coordination arrangements that involve digital health technology, provided that certain requirements are met.

The AMA voiced our opposition to the proposal requiring that a VBE have a compliance program, requiring that all VBE participants affirmatively recognize the oversight role, having more specific responsibilities on the accountable body or responsible person, implementing reporting requirements or mechanisms for obtaining access to participant data, and imposing a standard requiring either independence or a duty of loyalty. The AMA voiced our understanding for the need for accountability andfor compliance programs but argued that the proposals unnecessarily create additional burden without substantially reducing the risk of program fraud and abuse. **Consistent with the AMA's comments, the OIG decided that for purposes of these safe harbors in the final rule, the OIG will not require the VBE or its accountable body or responsible person to have a compliance program or to review patient medical records periodically.** The 010 will also not be requiring an attestation or other agreements from each VBE participant that it has a compliance program and conducts annual compliance reviews.

*Patient Engagement and Support:* 010 finalized a safe harbor to protect furnishing certain tools and support to patients in order to improve quality, health outcomes and efficiency. Importantly, this safe harbor is only available for value-based enterprise participants. The remuneration can be in-kind only andis limited to a $500 annual cap, adjusted for inflation, along with many other requirements.

*CMS-Sponsored Models:* OIO finalized a safe harbor to protect certain remuneration provided inconnection with certain models sponsored by CMS, thereby reducing the need for HHS to issue individualized fraud and abuse waivers for each model.

*Cybersecurity Technology and Services:* OIO finalized a standalone protection for donations ofcybersecurity technology and services, including certain cybersecurity hardware donation.

**Modifications to Existing AKS Safe Harbors**

*Personal Services and Management Contracts Safe Harbor*: The OIG finalized a new provision to the existing personal services and management contracts safe harbor which protects payments tied to achieving measurable outcomes that improve patient or population health or appropriately reduce payer costs.

*Local Transportation:* The OIG finalized its proposal to expand and modify mileage limits applicable topatient transportation in rural areas (expanded from 50 to 75 miles) and patient transportation from inpatient facilities post-discharge (removed all mileage limits). The OIG did not extend safe harbor protection to transportation of patients to any location of their choice or for nonmedical purposes.

*Electronic Health Records Items and Services Safe Harbor:* Like CMS, the OIG finalized several proposed changes to this safe harbor, including modifying the timing of certain required recipient contributions, permitting certain donations of replacement technology and removing the sunset provision.The OIG also did not finalize its proposal to modify the provision addressing the concept of information blocking, and instead removed that provision from the safe harbor entirely.

*Warranties:* OIG finalized its proposal to expand the warranty safe harbor to protect warranties covering a bundle of one or more items and related services.

*Accountable Care Organization (ACO) Beneficiary Incentive Programs:* The OIG amended the civil monetary penalty (CMP) rules by codifying a revision to the definition of "remuneration" added by theBipartisan Budget Act of 2018.

New CMP Exception

*Telehealth for In-Home Dialysis:* The OIG finalized its proposal to interpret and incorporate the Bipartisan Budget Act of 2018 statutory exception for furnishing telehealth technologies to certain in- home dialysis patients.

***



Added January 2022

## Attachment 8 Compliance Certification Form for Employees

### COMPLIANCE CERTIFICATION – EMPLOYEES

I certify that I have reviewed the Compliance Manual P&P for Employees and that the Compliance Program has been explained to me. I promise to comply with the terms of the Niagara County Department of Health Nursing Division Compliance Program and I understand that violation of these terms may lead to disciplinary action, up to and including the termination of my employment.

**Signature:** _____

**Name (print):** _____

**Date:** _____

## Attachment 8 Compliance Certification Form for Contracted Professionals

### COMPLIANCE CERTIFICATION – CONTRACTED PROFESSIONALS/OTHER

I certify that I have reviewed the Compliance Manual P&P and that the Corporate Compliance Program has been explained to me. I promise that I, and any person employed by me, will comply with the terms of the Niagara County Department of Health Nursing Division Compliance Program and I understand that violation of these terms may lead to disciplinary action, up to and including the termination of my relationship with the Agency.

**Signature:** _____

**Name (print):** _____

**Agency:** _____

**Date:** _____

## Attachment 9 Annual P & P Sign Off for Employees

**NIAGARA COUNTY DEPARTMENT OF HEALTH (NCDOH)**
**NURSING DIVISION** **EMPLOYEE:** _____

**INITIAL/ANNUAL POLICY AND PROCEDURE (P&P) SIGN OFF FOR EMPLOYEES**

**I have read the following NCDOH policies and procedures on the date(s) indicated. I understand the content of each policy and procedure and any questions I may have had have been answered.**

| | |
|---|---|
| **ABUSE AND NEGLECT – CHILD, ADULT AND DOMESTIC VIOLENCE** | / / |
| **ADVANCE DIRECTIVES POLICY** | / / |
| **BLOODBORNE PATHOGENS STANDARD** | / / |
| **COMPLIANCE PROGRAM** | / / |
| **DRUG FREE WORK PLACE** | / / |

I have read the NCDOH Drug Free Workplace P&P. I attest I am free from any impairment that would put a client at risk, including the habituation or addiction to any depressants, stimulants, narcotics, alcohol or other substances that may alter my behavior.

| | |
|---|---|
| **EMERGENCY PREPAREDNESS PLAN** | / / |
| **EXPOSURE CONTROL PLAN-OSHA/PESH REGULATIONS** | / / |
| **HAZARDOUS MATERIALS IN THE WORKPLACE (RIGHT-TO-KNOW PROGRAM) P&P** | / / |
| **HIPAA POLICIES** | / / |
| **CONFIDENTIAL HIV/AIDS INFORMATION** | / / |
| **MANAGEMENT OF OCCUPATIONAL EXPOSURES TO BLOODBORNE PATHOGENS AND OTHER POTENTIALLY INFECTIOUS MATERIALS** | / / |
| **PREVENTION OF INFLUENZA TRANSMISSION POLICY** | / / |
| **STANDARD PRECAUTIONS P&P** | / / |

**EMPLOYEE INFORMATION SHEET HEPATITIS B and HEPATITIS B VACCINE** **Date of Review** / /

I have read the NCDOH Employee Information Sheet Hepatitis B and Hepatitis B vaccine. I understand the content of the policy and any questions I may have had, have been answered.

**Have you ever been convicted of any crime (felony or misdemeanor)?** ☐ **Yes** ☐ **No** If yes, give details

**Have you ever been debarred or excluded from any federally funded healthcare program?** ☐ **Yes** ☐ **No** If yes, give details

**Completed form to the secretary of the Director of Nursing Services no later than:** _____

_____
**Employee Signature**

## Attachment 9 Annual P & P Sign Off for Contracted Professionals

**NIAGARA COUNTY DEPARTMENT OF HEALTH (NCDOH)**
**NURSING DIVISION**

**NAME:** _____

**POLICY AND PROCEDURE (P&P) SIGN OFF FOR CONTRACTED PROFESSIONALS**

**I have read the following NCDOH policies and procedures on the date(s) indicated. I understand the content of each policy and procedure and any questions I may have had have been answered.**

| | |
|---|---|
| **ABUSE AND NEGLECT – CHILD, ADULT AND DOMESTIC VIOLENCE P&P** | / / |
| **ADVANCE DIRECTIVES POLICY** | / / |
| **BLOODBORNE PATHOGENS STANDARD P&P** | / / |
| **COMPLIANCE PROGRAM P&P** | / / |
| **DRUG FREE WORK PLACE P&P** | / / |

I have read the NCDOH Drug Free Workplace P&P. I attest I am free from any impairment that would put a client at risk, including the habituation or addiction to any depressants, stimulants, narcotics, alcohol or other substances that may alter my behavior.

| | |
|---|---|
| **EMERGENCY PREPAREDNESS PLAN P&P** | / / |
| **EXPOSURE CONTROL PLAN-OSHA REGULATIONS P&P** | / / |
| **HAZARDOUS MATERIALS IN THE WORKPLACE (RIGHT-TO-KNOW PROGRAM) P&P** | / / |
| **HIPAA POLICIES** | / / |
| **P&P FOR CONFIDENTIAL HIV/AIDS RELATED INFORMATION** | / / |
| **MANAGEMENT OF OCCUPATIONAL EXPOSURES TO BLOODBORNE PATHOGENS AND OTHER POTENTIALLY INFECTIOUS MATERIALS (OPIM)** | / / |
| **PREVENTION OF INFLUENZA TRANSMISSION BY HEALTHCARE AND AGENCY PERSONNEL** | / / |
| **STANDARD PRECAUTIONS P&P** | / / |
| **EMPLOYEE INFORMATION SHEET HEPATITIS B and HEPATITIS B VACCINE** | / / |

I have read the NCDOH Employee Information Sheet Hepatitis B and Hepatitis B Vaccine. I understand the content of the policy and any questions I may have had, have been answered.

**Have you ever been convicted of any crime (felony or misdemeanor)?** ☐ **Yes** ☐ **No** If yes, give details

**Have you ever been debarred or excluded from any federally funded healthcare program?** ☐ **Yes** ☐ **No** If yes, give details

**Completed form to the secretary to the Director of Nursing Services' no later than:** _____

_____
**Signature**

## Attachment 10 OMIG Self Disclosure Program

# OMIG Self Disclosure Program

### Introduction

The New York State Office of Medicaid Inspector General (OMIG) originally issued self-- disclosure guidance for Medicaid providers on March 12, 2009. OMIG developed the self-disclosure guide in consultation with health care providers and industry professionals to give providers an easy-to-use method for disclosing overpayments.

OMIG designed this approach to encourage providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds that they identify through self-review, compliance programs, or internal controls that affect the state's Medicaid program. This guide is designed to help the provider through the process, point out advantages of self-disclosure, offer a user-friendly mechanism, and make providers aware of regulatory compliance requirements.

Since its inception, the Self-Disclosure Program has been successful and utilized extensively by providers, benefiting both the providers and the Medicaid program. As aresult of the OMIG Self-Disclosure Unit's experience and feedback, the agency has made enhancements and had added resources to the process.

The function is now supplemented by utilizing the OMIG\HMS PORTal, a Web-based site maintained by OMIG's contracted agent, HMS, Inc. The PORTal is an online mechanism used by OMIG\HMS to issue various projects and process recoveries in a simple, effective, and user-friendly electronic medium. OMIG has revised this guide toreflect the consolidation of the self-disclosure function within the agency to better servethe providers and the New York State Medicaid program.

#### Regulatory Authority

OMIG's Self-Disclosure Program, is in accordance with OMIG's enabling legislation:

> *[T} o, in conjunction with the commissioner, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. The provider's good faith self-disclosure of overpayments may be considered as* a *mitigating factor in the determination of an administrative enforcement action.* **N.Y.** PUB. HEALTH LAW§ **32(18).**

Self-disclosure and repayment of overpayments within 60 days of identification has become mandatory for Medicare and Medicaid providers under section 6402(a) of theAffordable Care Act (ACA) of 2010 and a mandatory part of New York's compliance programs under 18 NYCRR 521.

### When to Disclose

Providers should self-disclose **after** they fully investigate and confirm that an overpayment exists. OMIG's self-disclosure protocol assists and enables providers in making disclosures directly to OMIG or through its contracted agent HMS, which maintains the online OMIG PORTal. Through this process, providers who identify that they received reimbursement to which they were not entitled, whether caused by mistake, fraud, or accident, must disclose the parameters of the problem, cause, and itspotential Medicaid financial impact in accordance with the self-disclosure guidelines.

In addition, the federal Affordable Care Act requires providers to identify, self-disclose,explain, and repay overpayments within 60 calendar days of identification of the overpayment regardless of the financial threshold of participation in the Medicaid program.

The statute at 42 U.S.C. §1320a-7k(d)(1), requires a person who has received anoverpayment to:

1. ***report and return*** the overpayment to the Secretary, the State, an intermediary, acarrier, or a contractor, as appropriate, at the correct address; and
2. ***notify*** the Secretary, State, intermediary, carrier, or contractor to whom theoverpayment was returned in writing of the reason for the overpayment.

Failure to timely report and return any Medicare and Medicaid overpayment can have severe consequences, including potential liability under the False Claims Act, as well as the imposition of civil monetary penalties and exclusion from the Medicare and Medicaidprograms.

Overpayment Reporting should occur when the following conditions are met:

1. Overpayment is NOT included in another, separate review or an auditbeing conducted by OMIG, vendors, or OIG.
2. Overpayment is NOT related to a broader state-initiated rate adjustment,cost settlement, or other broader payment adjustment mechanisms. (These include retroactive rate adjustments, charity care, cost reporting,etc.)

The repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims.

**The Process**

Prior to contacting OMIG, the provider should fully investigate and determine the issue and prepare the disclosure including all the required information and documentation. Once an inappropriate payment is discovered, providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes. Each incident must be considered on an individual basis. Factors to consider include: identification of the exact issue, the amount involved,any patterns or trends that the problem may demonstrate within the provider's billing system, the extent of the period affected, the circumstances that led to the overpaymentand whether or not the organization has an **OMIG corporate integrity agreement (CIA)** which requires self-disclosure.

The providers may choose to self-disclose using one of two methods:

1. Following the Self-Disclosure Submission Guidelines (see Attachment **1**); or
2. Using the OMIG PORTal for electronic submission (see Attachment 2).

After receipt of the self-disclosure, the OMIG/HMS staff will consult with the provider and determine the most appropriate process for proceeding. OMIG/HMS staff will discuss the next steps which may include requesting additional information, verification of the overpayments and any regulatory clarification needed.

In the event that the provider is unable to determine if the self-disclosure issue resulted in non-compliance overpayments or has difficulty identifying the overpayments, OMIG staff can possibly assist the provider in the disposition of the issue. The provider, or itsdesignated agent, may request data for the sole purpose of quantifying and validating apotential overpayment (see Attachment 3 - Data Request from Providers).

The use of **statistical sampling** must be approved by OMIG and all documentationrelated to the review and extrapolation must be submitted to OMIG for review and approval. Data may be provided by OMIG to establish the appropriate universe andsampling method upon request and approval by OMIG.

To submit a self-disclosure or request data to develop same please send to:

Via Letter:

**The Office of the Medicaid Inspector General**
**Attention: Self-Disclosure Unit**
**800 North Pearl Street**
**Albany, NY 12204**

Via Email: **SelfDisclosures@omig.ny.gov**

**Access to Information**

Providers are expected to promptly comply with OMIG requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The OMIG is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilegeor work-product protection. Discussions with the provider's compliance officer, counsel,or other staff may be necessary to obtain information and agreement to complete the disclosure in a timely manner.

**Access to Data**

All documentation and data must be protected for confidentiality under the Health Insurance Portability and Accountability Act (HIPAA) by the provider and its representatives (staff, lawyer, or contractor). The US Department of Health and HumanServices' HIPAA guidance states that: The "Privacy Rule" requires that a covered entityobtain satisfactory assurances from its business associate that the business associate will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity. The satisfactory assurances must be submitted in **writing to OMIG, whether** in the **form of a contract or other agreement between the covered entity and the business associate.**

**Restitution**

All provider self-disclosures are subject to a thorough OMIG/HMS review to determine whether the amount identified is accurate. While repayment is encouraged and accepted as early in the process as possible, and will be credited toward the final settlement amount, the OMIG will not accept money, voids, and adjustments as full andfinal payment for self-disclosures prior to finalizing the review process.

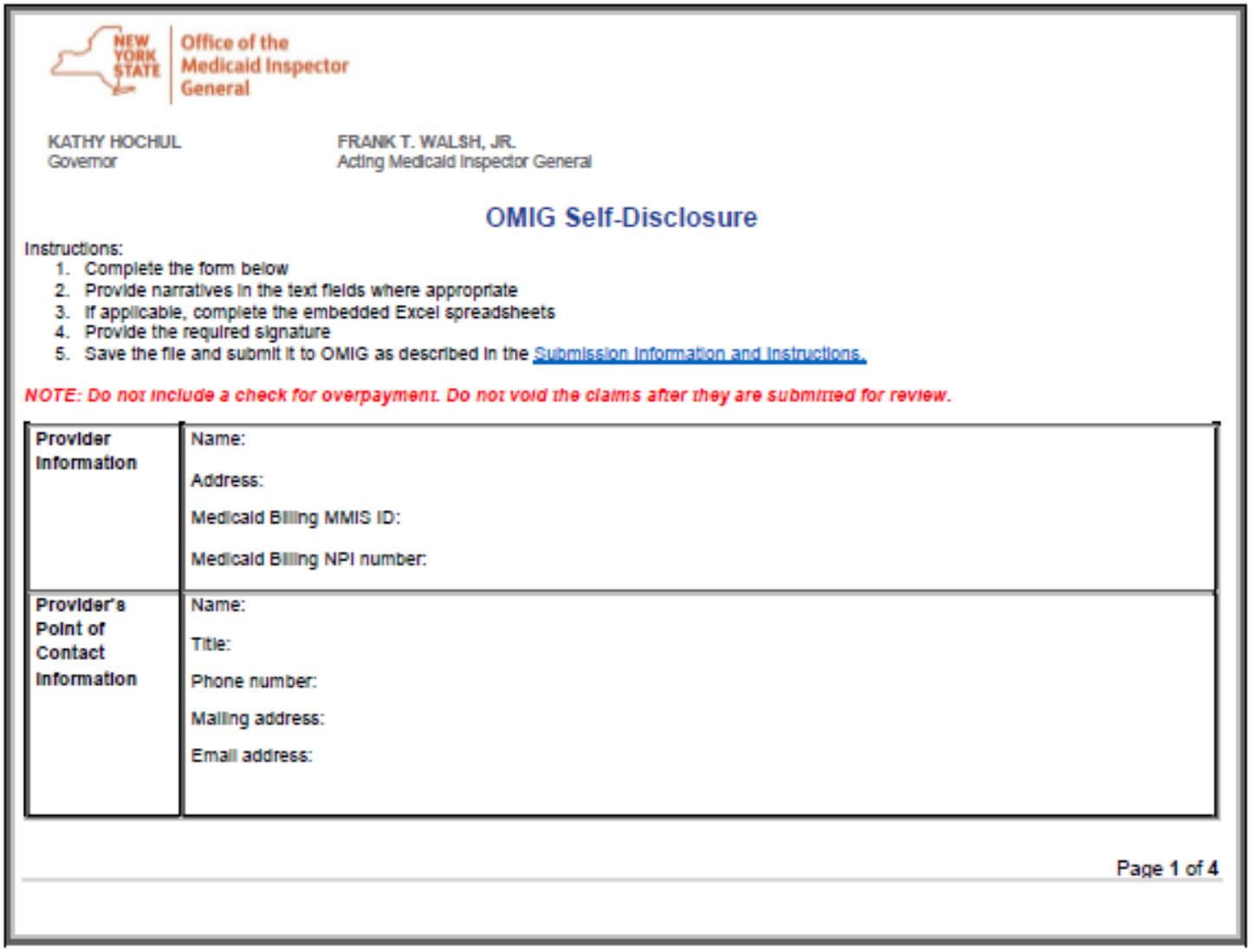
Once a repayment amount has been established, assuming full repayment has not previously been made, the OMIG expects the provider to reimburse the State of NewYork for the overpayment. Providers interested in extended repayment terms due tohardship will be required to submit audited financial statements and/or other documentation to assist the OMIG in making that determination. Once the repaymenthas been finalized, the OMIG will issue a letter indicating closure of the matter.

**Self-disclosure limitations**

The OMIG Self-Disclosure Program is designed to report and recover overpayments due back to the Medicaid program. Depending on the nature of the issue, the OMIG'sstaff may refer the matter through established audit or investigation processes or to other state agencies

Underpayments detected in the process or otherwise are not to be offset in the self-- disclosure process. **Underpayments must be re-billed to eMedNY and claims aresubject to system edits and verifications. Time-barred claims are pended and reviewed by the Office of Health Insurance Programs (OHIP) for disposition and consideration for payment.**

**OMIG Self –Disclosure Form**



NEW YORK STATE | Office of the Medicaid Inspector General

KATHY HOCHUL
Governor

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

## OMIG Self-Disclosure

Instructions:

1. Complete the form below
2. Provide narratives in the text fields where appropriate
3. If applicable, complete the embedded Excel spreadsheets
4. Provide the required signature
5. Save the file and submit it to OMIG as described in the Submission Information and Instructions.

*NOTE: Do not include a check for overpayment. Do not void the claims after they are submitted for review.*

| | |
|---|---|
| **Provider Information** | Name:<br>Address:<br>Medicaid Billing MMIS ID:<br>Medicaid Billing NPI number: |
| **Provider's Point of Contact Information** | Name:<br>Title:<br>Phone number:<br>Mailing address:<br>Email address: |

Page 1 of 4

| | |
|---|---|
| **Overpayment Information** | Amount of the overpayment:<br><br>Dates of service (DOS) the claims error or matter encompasses:<br><br>Names and titles of individuals who discovered the error or matter, involved in the error or matter, and involved in rectifying the problem:<br><br>Describe the error or matter that occurred:<br><br>Describe how the error or matter was found:<br><br>Actions taken to stop the error or matter and prevent recurrence:<br><br>Type of claims affected (check all that apply): ☐ Managed Care (list MCO/MLTC names):<br><br>☐ Medicaid Fee For Service (FFS) ☐ FFS APG (ambulatory patient group) ☐ FFS EPS (episodic)<br><br>☐ Other (*please provide additional explanation to assist in identifying your overpayment*)<br><br>Have the disclosed claims been voided or adjusted? (*If so please provide the date of the void/adjustment*):<br><br>**** Providers who wish to repay by voiding or adjusting claims, please do so prior to submission of this self-disclosure. ****|
| **Claims Data Form –**<br><br>Complete this form to disclose overpaid claims. | *To complete the Claims Data spreadsheet, double-click the spreadsheet below.*<br><br>  <br>Claims Data Form.xlsx |

**Mixed Payer Calculation Form –**

Complete this form to disclose Excluded Provider(s)

*To complete the Mixed Payer Calculation spreadsheet, double-click the spreadsheet below.*

**Mixed Payer Calculation Form**

The following formula is used to determine the repayment amount for Excluded individuals whose salaries were paid through mulitple sources.

* Fill in the sections highlighted in blue*

| | | | | | |
|---|---|---|---|---|---|
| **Enter dates worked & compensation earned while Excluded; 1 year per column.** | Enter Dates | Enter Dates | Enter Dates | Enter Dates | Enter Dates |
| Gross earnings | | | | | |
| Benefit & Welfare | | | | | |
| Pension | | | | | |
| Total | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| **Enter the revenue amounts below as found in the Provider's fiscal or calendar year records.** | | | | | |
| Total Revenue from all sources (including Medicaid) | | | | | |
| Total Revenue (Medicaid only) | | | | | |
| **This is the Provider's Medicaid Revenue %** | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| **Overpayment equals the Medicaid Revenue % mulitplied by the Total compensation.** | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| **Total Overpayment** | $0.00 | | | | |

*The undersigned affirms that the information contained herein and attached hereto is true and accurate, to the best of my knowledge.*

| Name | Electronic Signature |
| --- | --- |
| Title | Date |

**SUBMITTING THIS FORM:**

After completing this form, please save the file and submit it to OMIG as described in the Submission Information and Instructions.

## Attachment 11 Compliance Program Error Log

**NIAGARA COUNTY DEPARTMENT OF HEALTH**
**COMPLIANCE PROGRAM ERROR LOG**

| Date of Discover | Name of Individual | Description of Error | Remediation / Corrective Action(s) | Training | Policy Changes |
|---|---|---|---|---|---|
| | | | | **Describe:**<br><br>**Attendance:** | ☐ Yes ☐ No If yes, describe: |
| **Date of Discover** | **Name of Individual** | **Description of Error** | **Remediation / Corrective Action(s)** | **Training** | **Policy Changes** |
| | | | | **Describe:**<br><br>**Attendance:** | ☐ Yes ☐ No If yes, describe: |

Attachment 12 Compliance Program Notice

## NIAGARA COUNTY DEPARTMENT OF HEALTH
## NURSING DIVISION

### COMPLIANCE PROGRAM NOTICE

Niagara County Department of Health (NCDOH) Nursing Division holds itself to high standards of accountability for clinical, business and financial management.

In all agency endeavors, NCDOH Nursing Division employees are guided by the following agency philosophy: honesty, integrity, respect and fairness in all dealings with patients, vendors/suppliers, employees and the community.

In carrying out this philosophy, NCDOH Nursing Division has implemented and maintains a compliance program that emphasizes:

Prevention of wrong doing, whether intentional or unintentional; and

Reporting and investigation of questionable activities and practices, without consequences to the reporting party; and

Timely correction of any situation which puts the agency, its leadership, staff or patients at risk; and

The time frame for investigations, unless in the case of an extreme urgency, shall be one week.

Any interested party can report, without fear of retaliation, suspected instances of waste, fraud, abuse or any other questionable activity or practice. Reports may be submitted by mail, telephone, fax or e-mail.

Compliance Officer: Stacy Knott (716) 278-8596
Compliance Hotline: (716) 278-1935
Compliance Fax: (716) 278-1936

Address:
Niagara County Department of Health
Nursing Division – 3rd Floor
1001 11th Street
Niagara Falls, NY 14301-1201
Email: stacy.knott@niagaracounty.com

**PUBLIC HEALTH: PREVENT. PROMOTE. PROTECT.**

Public Health
Prevent. Promote. Protect.