



Rome Memorial Hospital

Corporate Compliance Program Manual

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ROME

MEMORIAL HOSPITAL

An Affiliate of St. Joseph's Health

Dear Rome Memorial Hospital Colleague:

The mission of Rome Memorial Hospital is simple. We provide quality healthcare with compassion. With a focus on our patients our collective vision is to deliver exceptional care for a healthier community.

To achieve our mission, we are guided by a common set of values that direct us in everything we do. The Hospital has a reputation, achieved and maintained through the integrity and ethical standards of our employees and medical staff, for conducting ourselves in accordance with the highest levels of ethical business conduct and in compliance with applicable laws and regulations. Because the health care environment continues to evolve at rapid pace, it is the commitment of Rome Memorial Hospital to maintain this reputation by enforcing the highest standards of ethics, efficiency and business conduct through a Corporate Compliance Program.

Regulatory compliance – making certain that we follow all laws and regulations that apply to us as a hospital and a business – is very important. Federal and State regulatory enforcement agencies continue to scrutinize health care providers' compliance with laws and regulations. Therefore, we take a proactive approach to assure that we continue to maintain our organizational ethics and business conduct practices by establishing a Corporate Compliance Program which is defined in this Manual.

A formal Corporate Compliance Program is integral to the achievement of these goals. It empowers employees and medical staff to detect any problems and provides a means to solve those problems. It is critical each of us understand our individual responsibility to not only personally adhere to these standards, but also actively participate in and promote compliance as representatives of the Hospital.

A Compliance Hotline and mailing address have been established for you to use confidentially to ask questions, seek guidance or report any situation you believe violates the provisions of this Program. I encourage you to bring any concerns you may have to the attention of our Corporate Compliance Officer so that we may further enhance the quality of our organization. Examples of information that could be reported on the hotline include: conflicts of interest, breaches of patient confidentiality, submission of bills not supported by the medical record, unethical conduct, etc. Employee human resource questions or concerns, such as job performance issues, discrimination, or abuse of overtime should continue to be reported directly to the Human Resources Department rather than through the hotline.

The Compliance Hotline is available 24 hours a day at (315) 338-7625 and will be answered by a voicemail system to take your information. The Compliance Officer will retrieve messages each day, and the information you provide in your message will be kept confidential, to the maximum extent possible. If you prefer, you may send your information in writing to Corporate Compliance Officer, 1500 N. James Street, Rome, NY 13440. You have my assurance that there will be no retribution or adverse consequences for asking questions or raising concerns about conduct or compliance issues.

As an organization we are committed to those ideals reflected in our Mission Statement and Code of Ethics. We must be equally committed to assuring that our conduct consistently reflects our words. So, I ask that you review this manual thoroughly. Your adherence to its spirit, as well as its specific provisions, is essential to our future.

Sincerely,

David Lundquist
President/Chief Executive Officer

Our Mission Statement

We provide quality healthcare with compassion.

Our Vision Statement

Exceptional people delivering exceptional care for a healthier community.

Our Value Statement

We commit to accountability, respect, integrity, innovation and excellence always.

Our Code of Ethics and Business Conduct

Definition and Purpose

The Rome Memorial Hospital Mission statement is based on the premise that the Hospital and its members are committed to ethical decision making and conduct. All Rome Memorial Hospital staff and associates are responsible for demonstrating personal, professional, and organizational integrity and high ethical values.

We are committed to the ethical treatment of those to whom we have an obligation:

- For our patients and their families, we are committed to providing compassionate, quality health care, delivered timely and at a reasonable cost;
- For our employees, we are committed to honesty, fairness and just management; providing a safe and healthy working environment; and respecting the dignity due everyone;
- For the communities where we live and work, we are committed to acting as concerned and responsible neighbors, reflecting all aspects of good citizenship;
- For our suppliers, we are committed to fair competition and the sense of responsibility required of a good customer; and
- For our payers, we are committed to appropriately coding and billing medically necessary patient charges based on services rendered, the medical record and in compliance with applicable laws.

These are the basic tenets of the Hospital's Code of Ethics. The ultimate goal in adhering to the Code is to ensure that we meet our commitment to ethical standards and comply with applicable laws and regulations. The Code is a critical element of the Hospital's Corporate Compliance Program. It is the responsibility of every governing body member, officer, employee, physician, volunteer, student and other agent to act in a manner that is consistent with policies set forth in the Code.

Why is this Important?

As the healthcare industry rapidly evolves, our ability to serve our patients and the community lies increasingly within in our ability to maintain our sense of integrity and ethics. Every day, we have to make hard choices and decisions. We have to tell people things they don't want to hear. Amid intense public and media scrutiny, we have to demonstrate that we recognize and accept our responsibility to behave and respond in an ethical manner not only to our patients, but also to our community and to our environment.

In such an environment, laws and regulations governing hospital practices are becoming more numerous and complex. The government has been investigating hospitals for non-compliance with laws and regulations at an ever increasing rate. In some cases, the consequences of these investigations have been financial penalties against the hospital and medical practices or loss of certification in the Medicare program for providers of care. Rome Memorial Hospital wants to make sure there continues to be no basis for charges of these types against the Hospital or its employees.

Our Corporate Compliance Program

Introduction

The Hospital adopted a Corporate Compliance Program (the Program) to demonstrate our commitment to comply with all federal and state laws and regulations.

The Hospital's Program applies to salaried and hourly staff, administrative personnel, contracted personnel, medical staff, volunteers, students and other agents (collectively referred to as “employees and other agents”). In addition, the Hospital’s compliance program applies to the RMH Retail Pharmacy, the RHCF and its staff. The RHCF is a separately licensed department of Rome Memorial Hospital. The RMH Retail Pharmacy is a for profit entity operating under the same corporate entity (Greater Rome Affiliates) as Rome Memorial Hospital.

Program policies and procedures have been established to ensure that employees and other agents have access to guidance and protocol that should be followed in performing their duties. See Attachment B for a list of corporate compliance program policies. **The policies and procedures set forth in this Program document are mandatory and must be followed as a condition of employment or affiliation.**

To obtain further information or guidance about applicable Hospital policies or laws and regulations, we urge you to contact our Corporate Compliance Officer, at (315) 338-7412 or the Compliance Hotline (315) 338-7625.

Common Areas of Compliance Risk

In order for the compliance program to achieve maximum effectiveness, all of Rome Memorial Hospital’s employees must play an integral part in the monitoring of the Hospital’s day-to-day operations. That means that each employee must be familiar with the federal, state and Hospital rules and regulations under which the employee works.

In moving toward such a state of familiarity, the Hospital must address one of the most common and significant areas of compliance exposure: federal health care programs. Federal health care programs, including Medicare and Medicaid, are regulated by many laws covering everything from coding of medical procedures and physician licensing and credentialing to record retention and the financial investments of physicians. Although this manual could not possibly cover all of the rules and regulations that are relevant to the Hospital, the Department of Health and Human Services’ Office of Inspector General (“OIG”) has identified a number of areas of particular compliance risk which entities operating in the health care industry must pay particular attention to. These risks are outlined in the OIG’s series of *Compliance Program Guidance’s*, which currently exist for hospitals, home health agencies, clinical laboratories and third-party medical billing companies, and include, among others:

- Billing for items or services not actually rendered;
- Billing for medically unnecessary services;
- “Up-coding” to a higher paying billing code than the code that reflects the actual service provided;
- “DRG Creep”, or using a higher paying Diagnostic Related Group code than the code that reflects the actual service provided;
- Providing outpatient services in connection with inpatient stays;
- Duplicate billing;
- Filing false cost reports;

- “Unbundling”, or billing separately for services or tests that should be billed together (in a “bundle”) in order to maximize reimbursement;
- Billing for discharges in lieu of transfers;
- Failure to refund credit balances;
- Participating in incentive programs that violate the anti-kickback statute or similar federal or state statutes;
- Participating in joint ventures;
- Creating financial arrangements between hospitals and hospital-based physicians;
- Violations of the Stark physician self-referral laws;
- Knowingly failing to provide covered services or necessary care to HMO members; and
- Violations of the patient anti-dumping statute.

The OIG issues its annual work plan which outlines areas that the OIG has targeted for review for the upcoming year. In addition, New York State has required hospitals to implement a compliance program similar to the Federal requirements. Details of the New York State program requirements can be found in Attachment A.

Quality and Compliance

Medicare and other payers are increasingly linking payment to quality of care. There is a shift that is occurring where Medicare reimbursement is no longer just for procedures performed, but for the outcomes of those procedures. There is a greater demand for transparency and information about the delivery of quality care and there are also enforcement actions that are targeting a provider’s failure to provide adequate care. There are some specific areas of quality that link the clinical and financial aspects of healthcare. These areas include: medically unnecessary services and failure of care, provision of care that is so deficient that it amounts to no care at all, and failure to meet accepted standards of care (substandard care).

At Rome Memorial Hospital, quality of care is a very important aspect of the Hospital’s mission and there are several committees that provide oversight of our Quality program. The Hospital Board of Trustees is ultimately responsible for quality of care and they have assigned the Quality Council oversight responsibility. The Quality Council reviews feedback from several committees on any issues pertaining to quality. The Performance Improvement Committee is a medical staff committee that meets bi-monthly and is primarily responsible for evaluating the peer review of each medical staff department. Utilization review is also a very important aspect of the Quality program at Rome Memorial Hospital and is overseen by the Performance Improvement Committee, which reports up through the Quality Council. This involves the review of cases for medical necessity, utilization of resources as well as appropriateness of care. The RHCF Quality Committee of interdisciplinary team members meets on a regular basis and reports to the Hospital’s Quality Council.

The Vice President and Chief Quality Officer (CQO) oversees all aspects of the Hospital’s Performance Improvement department. The CQO, along with the Compliance Officer and Director of Performance Improvement are members of the Compliance Management Committee and the Quality Council and are the liaisons between the Compliance and Quality programs at Rome Memorial Hospital. All issues of quality that impact reimbursement and compliance are fully investigated to ensure that all payments are appropriate. The integration of quality and compliance continues to evolve as the legal and regulatory requirements change over time.

Compliance Program Structure

The Hospital's corporate compliance program is structured around the essential elements of effective corporate compliance programs identified in the *Federal Sentencing Guidelines*, as revised in 1991, and adapted to hospitals in 1998 by the Department of Health and Human Services' Office of Inspector General publication *Compliance Program Guidance for Hospitals*, as well as the Office of Medicaid Inspector General, NY State Social Services Law Section 363-d and corresponding regulations at 18 NYCRR Part 521 that require providers in the medical assistance program (Medicaid) to have an effective compliance program. Briefly, the essential elements are:

1. **Compliance Standards and Procedures** - The development and distribution of written standards of conduct, as well as written policies and procedures that promote the hospital's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;
2. **Compliance Oversight Responsibility** - The designation of a corporate compliance officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who report directly to the President/CEO and the governing body, the Board of Trustees;
3. **Employee Training and Education on Compliance** - The development and implementation of regular, effective education and training programs for all affected employees;
4. **Reporting of Noncompliance** - The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation;
5. **Enforcement and Discipline** - The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements;
6. **Compliance Monitoring and Auditing** - The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified compliance risk areas;
7. **Response and Prevention** - The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals; and
8. **Identification of Overpayments**- A process to refund any identified overpayments, as required by law, that Rome Memorial Hospital discovers, that may have been received inadvertently from Medicare, Medicaid or third party payor.

The Hospital has adopted an oversight structure for its corporate compliance program. This structure includes the Corporate Compliance Officer, the Compliance Committee of the Board of Trustees, the Management Compliance Committee, and Compliance Liaisons representing the various departments existing within the Hospital, Legal Counsel and the Chief Medical Officer. All of these entities are firmly committed to supporting you in meeting the Hospital's high legal and ethical standards, and are corporately responsible for:

- Training and educating employees and associated entities in the Hospital's corporate compliance program, including continuing education as changes in the regulatory environment occur;
- Conducting ongoing risk assessments, random monitoring and auditing activities to identify and correct any potential violations of the corporate compliance program;
- Maintaining an organizational reporting and response protocol for compliance-related questions, concerns or issues;
- Enforcing the Hospital's corporate compliance program through consistent application of appropriate disciplinary actions;
- Updating the corporate compliance program over time as necessary.

The Board of Trustees

The Compliance Committee of the Board of Trustees (“Board Compliance Committee”) and the full Board of Trustees serves as the umbrella oversight body of the corporate compliance program. The Board Compliance Committee is responsible for directing the duties of the Corporate Compliance Officer (“CCO”) and the Management Compliance Committee, and ensures that these two entities have the appropriate support and access to necessary resources required to carry out those duties. Based on reports and information provided by the Corporate Compliance Committee and the Management Compliance Committee, the Board Compliance Committee will provide reports to the full Board of Trustees on a periodic basis.

Corporate Compliance Officer

The CCO serves as the centerpiece of the Hospital’s corporate compliance program. The CCO has direct access to the Hospital’s Board of Trustees and Chief Executive Officer. An integral part of developing, designing and implementing the Hospital’s entire compliance program, the CCO will also be the primary force behind the evolution of the corporate compliance program as the health care regulatory and economic environment changes over time. In addition, they will be the principal figures in providing guidance in response to ambiguous and difficult compliance issues, and overseeing the day-to-day operations of the compliance program, including training and education, monitoring and auditing and investigations.

The Management Compliance Committee

The Management Compliance Committee (“MCC”) is a group of Hospital management and staff that provide support for the day-to-day execution, maintenance and updates of the compliance program. Chaired by the CCO, the MCC benefits the Hospital by bringing to the compliance program the perspectives of individuals with varying responsibilities within the Hospital, such as operations, finance, audit, human resources, utilization review, discharge planning, medicine, nursing, coding and legal, as well as employees and managers of key operating units.

The Compliance Liaison

The Hospital recognizes the distinct and critical role that each department plays in effectively building compliance into the daily aspects of its operations. Accordingly, each department director or manager also functions as a “compliance liaison” reporting to the CCO and the MCC, and assumes responsibility for ongoing, department-specific guidance and support for compliance-related activities.

Legal Counsel

The Hospital has retained the services of Hancock & Estabrook LLP to assist the Board of Trustees, Hospital management, the CCO and the MCC to identify and interpret federal, state and municipal laws and regulations as they apply to the Hospital, assist in updating our corporate compliance program, and provide further legal advice and perspective with respect to any potential regulatory compliance issues.

The Chief Medical Officer

The Hospital recognizes the pivotal role that community physicians play in making our commitment to compliance with the laws and regulations that govern patient care services a success. Thus, the Hospital’s Chief Medical Officer holds a prominent place on the MCC, with responsibility for communicating both the elements of our corporate compliance program to the medical staff and updates and changes to the program.

Training and Education

In order for our corporate compliance program to be effective, every employee and affiliate of the Hospital must be aware of the importance of the Hospital's compliance efforts and understand his or her individual role and responsibilities in the corporate compliance program. In order to achieve that state of awareness and understanding, the Hospital has implemented a network of training and education seminars and continuing education courses geared around the specifics of our corporate compliance program and current compliance concerns. All employees are required to complete the basic corporate compliance training and education program given at orientation or the annual health fair and attend additional classes as necessary which varies by the employee's classification and functional responsibilities.

The CCO, in coordination with the Management Compliance Committee and department directors and managers, develop training and education seminars addressing department-specific compliance issues. You may be required to attend one or more of these department-specific training and education seminars, particularly if you work in certain high-risk areas or departments. These training seminars will be conducted both internally and externally.

For further information about specific training and education programs, continuing education courses or the training and education requirements for your employee classification and functional responsibility, please contact Rome Memorial Hospital's Corporate Compliance Officer, at extension 7699 or at (315) 338-7699.

The Compliance Hotline

Any type of error, weakness in controls or wrongdoing, whether intentional or not, can subject the Hospital and involved employees and other agents to civil and criminal penalties. With this in mind, the Compliance Hotline (ext. 7625 or 338-7625) is available 24 hours a day for employees and other agents to ask compliance-related questions, raise concerns and report possible errors or violations of the compliance program. The Hotline voice mail system will record the question, concern or report, at which point the CCO or designee will investigate and resolve the issue as promptly as possible. All information received by the Compliance Hotline will be kept confidential, to the extent possible, if the individual caller so chooses in order to protect the anonymity of the caller. The Compliance Hotline is intended to be used for issues relating to Corporate Compliance. Issues concerning wages, benefits or other personnel questions should be made directly to the Human Resources Department.

Organizational Reporting and Response

The Hospital has adopted an Organizational Reporting and Response Protocol to guide the Board Compliance Committee, the Corporate Compliance Officer, and the Management Compliance Committee through the process of responding to a compliance-related question, concern or issue identified through the Hospital's Hotline or through other means. This protocol outlines the process the Hospital will follow in responding to incidents of potential non-compliance with laws and regulations. Please refer to Compliance policies CC-009 and CC-010 for further guidance.

Please note that employees and other agents are expected to promptly raise issues of concern or report suspected violations. Also note that the Hospital policy prevents retribution and retaliation against employees who in good faith report violations or incidents of possible unethical behavior.

The Hospital is committed to investigating all reported concerns promptly and confidentially. In cases where the results of an investigation substantiate reported violations, the Hospital policy stipulates the initiation of corrective action, including, as appropriate, prompt restitution of any overpayment amounts,

notification of the appropriate governmental agencies, institution of disciplinary action and implementation of systemic changes to prevent similar violations from recurring in the future.

Enforcement and Discipline

It is the responsibility of each employee to adhere to and help further the Hospital's compliance efforts in performing his/her job duties. Any acts of misconduct that disrupt or interfere with the safe and productive operation of the Hospital can result in disciplinary action. The precise disciplinary action will depend on the nature, severity and frequency of the violation, and may result in any combination of verbal warnings, written warnings, suspension, termination or restitution.

Monitoring and Auditing

Ongoing, independent, random monitoring and auditing procedures by internal and external entities are crucial to identifying and promptly rectifying any potential compliance violations and ensuring the ongoing effectiveness of our compliance program. The Hospital utilizes annual work plans published by the Office of Inspector General and the Office of the Medicaid Inspector General to assist in the development of its Annual Compliance Work plan. The Corporate Compliance Officer, with the assistance of the Management Compliance Committee and department directors and managers, is primarily responsible for commissioning and conducting these procedures and reporting the results to the Board Compliance Committee.

Supervisors, Managers and Directors are encouraged to request specific reviews or audits of their department's compliance activities. To ensure that important duties under Hospital's Compliance Program are properly delegated, the Corporate Compliance Officer shall maintain documentation of all significant requests for reviews or audits in relation to the Compliance Program. Requests shall be reviewed and approved in accordance with compliance policy CC-010 *Responding to Reports of Potential or Actual Violations*.

Your Role and Responsibilities

Whether you are an employee of the Hospital, a contractor or merely enjoy Hospital staff privileges, our corporate compliance program relies on you to provide the Hospital with the support necessary to ensure that we operate within the boundaries of applicable laws, regulations and Hospital policies at all times. Without you, the corporate compliance program cannot succeed. Therefore, the Hospital has entrusted you with the responsibility of:

- Being honest in your dealings with patients, vendors, payers and fellow employees;
- Becoming familiar with and acting in accordance with the Hospital's Standards of Conduct as well as the policies, procedures, laws and regulations that govern the performance of your job;
- Seeking advice or clarification when you are uncertain about how to apply the Standards of Conduct, or what the Hospital expects in terms of proper business actions or practices;
- Listening and responding to questions, complaints or concerns expressed by patients, family members, customers or co-workers; and
- Reporting violations of the Standards of Conduct or any policies, procedures, laws or regulations to your supervisor, your Compliance Liaison, your Human Resources representative, the CCO, any member of the MCC or the anonymous and confidential Compliance Hotline set up for compliance-related issues.

The compromise of these responsibilities by any employee in any position due to personal preference, inconvenience or business pressure is a serious matter that can lead to disciplinary actions or termination of your relationship with the Hospital. Therefore, the Hospital asks you to take your commitment to compliance very seriously. In return, the Hospital pledges to provide you access to appropriate resources, training and education programs, and personal guidance available regarding compliance issues that you may encounter in conducting your job responsibilities.

If you have any questions about your role and responsibilities in our corporate compliance program or any compliance-related questions in general, please feel free to call our Corporate Compliance Officer at (315) 338-7412 or our Compliance Hotline at (315) 338-7625.

Policies

The following is a brief overview of the general policies covered by our Hospital compliance program. A listing of specific corporate compliance policies is attached to this document and should be referred to for more specific information.

- **Confidentiality**

- We will respect any confidences received while on duty from patients or personnel, and avoid gossip.
- We will discuss patient welfare only with those directly involved in the care and treatment of the patient.
- We understand that recommending or discussing physicians with the patient's family or patients is unethical.
- We understand that hospital and patient business is confidential. When leaving the Hospital, we will leave all knowledge of the patients and the Hospital at the Hospital.
- Whispering outside a patient's room is inappropriate and may be misinterpreted by a patient or family.
- All visitors will be treated with courtesy.
- A patient's privacy is to be respected at all times. Staff will always knock gently before entering a room if the door is closed.
- Staff will be sensitive to the unspoken word, and will always speak clearly and distinctly when speaking.

- **Gifts and Gratuities**

Gifts of cash or cash equivalents (e.g. gift certificates) are never permissible regardless of the amount. No employee shall accept gifts or gratuities from a patient unless directed to the department as a whole. Please refer to Administrative policy G-001 *Gifts, Gratuities and Conflicts of Interest* for more information.

- **Admission and Discharge**

The policy of the Hospital is to accept all patients requiring care and treatment following recommendation for admission by an active member of the Medical Staff, and falling within the clinical services available in this facility. The RHCF admission and discharge process includes a screening process to ensure appropriate quality care needs can be met and follow all applicable regulations and policies.

- **Marketing**

All information provided to the community related to marketing or advertisement of the Hospital services will be made in an ethical and legal manner consistent with the mission statement of the organization. All statements made to the public will be valid and will be substantiated publicly upon request.

- **Not-For-Profit Tax Exempt Status**

As a charitable organization, we will conduct business in compliance with all IRS regulations governing tax-exempt organizations and refrain from any conduct resulting in private inurement or benefit issues.

- **Administration and Recording of Health Care Services**

Patient care must be necessary, appropriate and well documented. We must ensure the medical necessity of the care provided and verify patient eligibility. In addition, we will accurately record all services provided, documenting physician authorization when necessary. Improper coding of services and care provided (i.e., up-coding, fragmentation, use of obsolete or inappropriate coding) will not be tolerated and will result in immediate disciplinary actions.

- **Contract Bids, Negotiations, and Awards**

For all proposals, bid preparations or contracting negotiations, we will make certain that all statements, communications and representations to prospective partners or suppliers are accurate and truthful. Once awarded, all contracts must be performed in compliance with specifications, requirements and clauses. In buying goods or services, we will treat all suppliers uniformly and fairly. In deciding among competing suppliers, we will objectively and impartially weigh all facts and avoid even the appearance of favoritism. Established policies and procedures will be followed in the procurement of all goods and services.

- **Conflict of Interest**

The Hospital recognizes the potential for conflicts of interest exist for board members, employees and physicians. Generally, any relationship, influence or activity that might impair ones ability to make objective and fair decisions when performing their duties should be avoided. Potential conflicts of interest include: employee outside employment, accepting gifts, related party transactions, arrangements, contracts or compensation plans. See Administrative policy G-001 *Gifts, Gratuities and Conflicts of Interest* for more information.

- **Billing and Claims**

The Hospital conducts only business practices that are legal and consistent with the organizational mission statement. Personnel are provided with the Hospital's Standards of Behavior and are required to adhere to these standards as set forth by the organization. We will generate billing and claims accurately reflecting that services rendered are supported by relevant documentation and are submitted in compliance with applicable laws, regulations and government program requirements (such as Medicare, Medicaid, TRI-CARE, etc.). We will never submit improper, false, fictitious or fraudulent claims to any government or private health care program. We will assist our patients in understanding the cost of their care and attempt to resolve billing questions and conflicts to the satisfaction of the patient. The Hospital shall refund all overpayments received within the required timeframes set by federal and state law.

- **Business and Financial Record Integrity**

Business integrity is a key principle for the selection and retention of those who represent the Hospital. Physicians, consultants or agents must express their willingness to comply with our policies and procedures and will never be retained to circumvent our ethical values and virtues.

- **Controlled Substances**

The Hospital will comply with all regulations governing the management and distribution of controlled substances. Specifically, no employee or physician affiliated with the Hospital will illegally distribute any controlled substances, including prescription drugs. In addition, expired, adulterated or misbranded pharmaceutical drugs may not be distributed or diverted. Medical and infectious waste will be properly handled and disposed of in accordance with the appropriate regulations.

- **Promoting a Positive Work Environment**

The Hospital will provide all employees a work environment in which they feel respected, satisfied and appreciated. Employees will be hired, promoted and compensated according to their qualifications and performance. Harassment or discrimination of any kind, especially involving race, color, disability, age, ethnic or cultural background, sexual orientation and veteran or marital status is unacceptable and will not be tolerated.

- **Bribes, Kickbacks, and Inappropriate Referrals**

The Hospital will comply with Medicare and Medicaid anti-kickback stipulations that no employee or physician knowingly and willfully offer, pay, solicit or receive compensation (i.e., in cash or "in kind" consideration) in connection with the referral of patients or acquisition of items for services. Accepting or paying bribes or kickbacks, obtaining the proprietary data of a third party, or gaining inside information or influence are just a few examples of what could give us an unfair competitive advantage and result in violations of law.

- **Antitrust and Trade Laws**

The Hospital will comply with federal and state antitrust laws. These laws address agreements and practices resulting in the restraint of competition including boycotting suppliers, discussing pricing or patients with competitors, implementing unfair or deceptive business practices, and misrepresenting services.

- **Work Safety**

The Hospital will comply with environmental, health and safety laws and regulations. Providing a drug-free, safe and healthy environment is of the utmost importance. Observe posted warnings and regulations. Any

accident or injury sustained on the job, or any environment or safety concern should be reported immediately to the appropriate management.

▪ **Agents and Independent Contractors**

The Hospital is committed that all organizations acting as agents on its behalf, such as consultants and independent contractors, will comply with the Program. A brochure outlining the Hospital's code of ethics is sent to all new consultants and contractors utilized by the Hospital.

The Hospital will not conduct business with consultants and independent contractors that have been excluded from participation in the Medicare and Medicaid programs.

▪ **OIG/OMIG Exclusion Check Policy**

The OIG/OMIG has authority to exclude individuals and entities from the Federal and State Health Care Programs. The OIG also has the authority to assess penalties to providers that violate the law by employing or contracting with an excluded individual or entity. An individual or entity is most commonly excluded for civil or criminal health care fraud and abuse. Exclusion could occur for fraud and abuse circumstances that were not intentional however also in circumstances when it was intentional.

RMH is prohibited from employing, contracting, or conducting business with consultants, with any employee, agent or vendor who is listed by the OIG/OMIG as debarred, excluded or otherwise ineligible for participation in Federal and State Health Programs. This prohibition is necessary to ensure RMH receives appropriate Federal healthcare program reimbursement for items and/or services provided to patients.

Any employee, agent or vendor who is charged with criminal offenses related to health care, must be removed from direct responsibility or involvement in any Federal and State Health Program until resolution occurs. If resolution results in conviction, debarment or exclusion of the employee, agent or vendor, the Health Care Center's Corporate Compliance Committees (Board and MCC) must immediately review the case and proceed with termination of the contract or employment.

RMH shall terminate conditional employment or a conditional contract upon receiving results of the individual or organization being excluded from participation in Federal Health Programs until which time that they are not on the list.

There is a process in place to verify that new employees and providers are not excluded from the Medicare or Medicaid program. This occurs during the employment process and credentialing phase for providers.

There is a monitoring process to ensure that all existing providers and employees are not excluded by OIG or OMIG.

▪ **Compliance Training & Education Policy**

The Hospital's initial and ongoing training program shall:

- Highlight the importance of a Corporate Compliance Program;
- Summarize Federal and State fraud and abuse laws.
- Mandatory annual training for all employees
- Specialized training available for departments, individuals and Board Members
- Periodic compliance trainings and education sessions will be developed and scheduled by the Corporate Compliance Officer

▪ **Billing and Claims Submission**

When claiming payment for RMH or professional services, RMH has an obligation to its patients, third party payors, and the Federal and state governments to exercise diligence, care and integrity with respect to

billing and claims submission. The right to bill the Medicare and Medicaid programs, conferred through the award of a provider number or supplier number, carries a responsibility that may not be abused.

RMH is committed to maintaining the accuracy of every claim it processes and submits. Many people, throughout the Hospital System, have responsibility for entering charges and procedure codes. Each of these individuals is expected to monitor compliance with applicable billing rules.

Any false, inaccurate or questionable claims should be reported immediately to a direct supervisor or to the Corporate Compliance Officer. Examples of false claims include:

- Claiming reimbursement for services that have not been rendered,
- Filing duplicate claims,
- “Up-coding” to more complex procedures than were actually performed,
- Including inappropriate or inaccurate costs on cost reports,
- Billing for a length of stay beyond what is medically necessary,
- Billing for services or items that are not medically necessary and
- Failing to provide medically necessary services or items.

There are steep fines, penalties and exclusions from the Federal and State Health Care Program that can be assessed for providers who are found to have submitted false claims under the Civil and Criminal False Claims Act.

The Fraud Enforcement and Recovery Act of 2009 (FERA) signed into law May 2009, implemented significant changes to the federal false claims act by expanding the scope of the false claims act liability and makes it possible to prove fraud against the government easier based on the revised law by widening the definitions of various key words and phrases.

- **Annual Compliance Work Plan**

The Corporate Compliance Officer is responsible for developing an annual compliance work plan and submits it to the Compliance Committee for feedback. This work plan describes the areas that will be reviewed, type of review, responsible party, and approximate timeframe of the scheduled review. Any changes to this work plan should be discussed at the Compliance Committee meetings. The work plan should also be shared with the Board of Trustees on an annual basis.

- **Disciplinary Actions and Sanctions**

After an investigation, if the concern reported requires disciplinary action, the disciplinary process will proceed per policy as outlined in the *Human Resources Progressive Disciplinary Policy*.

It is important to note that depending on the severity of the non-compliant behavior, progressive discipline is not required as the Hospital is an at-will employer.

It is expected that employees and medical staff will report compliance issues. If it is found that an employee or a group of employees did not report compliance issues that they were aware of, they will be subject to discipline. The RMH’s *progressive disciplinary policy* describes sanctions for (1) failing to report suspected problems (2) participating in non-compliant behavior and (3) encouraging or permitting active or passive non-compliant behavior.

Sanctions, which are penalties imposed, can result in not only disciplinary action, but also the removal of certain employment privileges, contract penalties, Board Membership, and discharge from employment and in some cases civil and / or criminal prosecution from a government agency against an employee or medical staff member. Executive management would be involved with recommending any sanctions needed, as this is not an all inclusive list.

Employees and medical staff may also be subject to disciplinary action for:

- Failure to perform any of the required compliance training, and failure to complete any assigned compliance assignments.
- Failure of management personnel to detect non-compliance with their department's applicable policies, where reasonable due diligence on the part of the Director or Executive Manager would have led to the discovery of such non-compliance.

▪ **Compliance Program Effectiveness**

This Corporate Compliance Program shall be reviewed annually by the Management Compliance Committee, Corporate Compliance Officer and Chief Executive Officer to evaluate the effectiveness of the plan and to determine if changes and/or revisions are necessary. The annual evaluation shall be promptly submitted to the Board Compliance Committee for consideration.

There are a few methods RMH will use to demonstrate the effectiveness of the compliance program.

1. That there have been reports made to the Corporate Compliance Officer (either directly, through the hotline or report form). This indicates that staff is aware of the program and the reporting systems available.
2. That there are written reports that summarize specific compliance reviews/internal audits that were conducted. Ideally, there will be reviews conducted proactively from knowledge of a high risk area along with reviews conducted reactively by a concern reported.
3. Attendance rates for annual compliance training.
4. Corporate Compliance Committee meeting minutes that demonstrate the topics addressed and actions taken.
5. That there have been refunds made to Medicare or Medicaid for overpayments received in error. Subsequently, refunding of overpayments discovered as part of an internal audit is typically a routine procedure at the conclusion of the internal audit. Alternatively, if overpayments are found on a case-by-case basis, those too will be refunded timely and appropriately.

When any overpayments are discovered, RMH will review the occurrence to determine if the over payment rises to the level of self-disclosure reporting. OIG and OMIG both have 'self disclosure procedures' that are available to providers online that provide details on how to self-disclose any intentional and/or widespread systemic compliance issues that resulted in significant overpayments. RMH will follow the self disclosure protocols if necessary, with the assistance of legal counsel.

Agents and Independent Contractors

The Hospital is committed that all organizations acting as agents on its behalf, such as consultants, Board Members, and independent contractors, will comply with the Compliance Program. The Hospital's code of ethics is shared with all new consultants and contractors utilized by the Hospital. The Hospital will not conduct business with consultants and independent contractors that have been excluded from participation in the Medicare and Medicaid program.

▪ **On-Site Government Investigation or Search Warrants**

An investigation could be commenced during any time of the day, evening or night. Government officials could be from the OIG, DOJ, Federal Bureau of Investigations (FBI), United States Attorneys Office, the Fiscal Intermediary (FI) (Empire Medicare), the State Attorney General's Office (AG), the State Department of Health (DOH) or OMIG. All employees and agents should follow the appropriate steps should a Government Agent present him/her self at RMH. The same procedure is in place with or without a search warrant being presented. The following steps apply to government agents/search warrants:

- 1) Immediately notify the department Director or administration
- 2) The Director/Administrator must notify the Corporate Compliance Officer and President/CEO immediately upon contact from governmental agencies

- 3) Do not inadvertently waive personal or RMH rights such as the attorney-client privilege, the right to counsel and the right against self-incrimination.
- 4) Upon initial contact the employee or agent should only provide the contact information of the Corporate Compliance Officer and President/CEO. Employees and agents do not have to answer any questions prior to the appropriate parties' arrival.

The President/CEO or designee will notify Hospital Counsel. Hospital Counsel will direct the investigation, in consultation with Executive Leadership.

- **Medicaid Compliance Certification**

OMIG and DRA require all providers to certify that a compliance program is in place that meets the requirements specified by law.

- **Compliance monitoring and auditing**

Compliance monitoring and auditing procedures will be implemented that are designed primarily to determine the accuracy and validity of the billing and coding submitted to federal, state and private health care programs and detect other instances of potential misconduct by employees and medical staff.

Random samplings of records drawn from a cross-section of departments will be conducted on an annual basis. Specific monitoring and auditing plans will be included in the annual compliance work plan. It will include periodic tests of claims submitted to Medicare, Medicaid, and other health plans. It reviews the accuracy of the work of coding and billing personnel and patient registration representatives. For quality of care/medical necessity reviews, claims review will also include care provided by nursing and medical staff.

This provides a system for routine identification of compliance risk areas which is required by OMIG. OMIG requires a mandatory evaluation of four areas on a regular basis: (1) credentialing of providers (2) mandatory reporting (3) governance and (4) quality of care.

The Corporate Compliance Committee meeting minutes will provide documentation to demonstrate the compliance topics that are discussed and addressed

- **HIPAA**

The Hospital is committed to ensuring compliance with the Health Insurance Portability and Accountability Act. Initial HIPAA training is provided at employee orientation, annually thereafter and as necessary at the discretion of the Corporate Compliance Officer.

Questions and Answers

This Manual is not intended to provide answers to every question that you may have about the Hospital's policies, laws, or regulations. The following questions and answers are intended to increase your understanding of how the specific guidelines must be applied.

Q. If I have a question about workplace conduct or saw something that I thought was wrong, whom should I contact?

A. The Hospital has provided several resources for you to turn to with such concerns. We first encourage you to discuss the issue with your supervisor. However, if for any reason you do not feel comfortable talking to your supervisor or if your supervisor did not answer the question or address the problem to your satisfaction, you do have other options. You may also contact the Human Resources department, the Corporate Compliance Officer, or call the compliance hotline at extension 7625 (338-7625).

Q. If I report something suspicious, will I get in trouble if my suspicions turn out to be wrong?

A. As long as you honestly have a concern, Hospital policy prohibits your being reprimanded or disciplined. As a Hospital employee, you have the responsibility to report suspected problems. In fact, employees may be subject to discipline if they witness something but do not report it. The only time someone will be disciplined for reporting misconduct is if he or she knowingly and intentionally reports something that he or she knows to be false or misleading in order to harm someone else.

Q. What should I do if my supervisor asks me to do something that I think violates the Hospital's Standards of Conduct policy, or is illegal?

A. Do not do it. No matter who asks you to do something, if you know it is wrong, you must refuse to do it. You must also immediately report the request to a level of management above your supervisor or to the Corporate Compliance Officer.

Q. How do I know if I am on ethical "thin ice?"

A. If you are worried about whether your actions will be discovered, if you feel a sense of uneasiness about what you are doing, or if you are rationalizing your activities on any basis (such as perhaps the belief that "everyone does it"), you are probably on ethical "thin ice". Stop, step back, consider what you are doing, get advice, and redirect your actions to where you know you are doing the right thing.

Q. In preparation for an accreditation visit, my supervisor has asked me to review medical records and to fill in any missing signatures and dates. May I do this?

A. No. It is absolutely wrong to sign another healthcare provider's name in the medical record or add missing dates. It is part of our basic integrity obligation to provide only complete and fully accurate information to accrediting groups.

Q. A patient with a chronic health condition is frequently admitted to our facility for treatment. He routinely tips his primary nurse around \$10. May the nurse accept it?

A. No. Cash gifts must never be accepted from anyone with whom we have a business relationship.

Q. May a department or individual accept a basket of fruit or flowers that a patient sent?

A. Yes. Gifts to an entire department may be accepted if they are consumable or perishable. Individual gifts are not appropriate.

Q. Do the conflict of interest policies apply to distant relatives, such as cousins or in-laws or friends?

A. The conflict of interest policies generally apply to members of your immediate family. However, if any relationship could influence your objectivity or create the appearance of impropriety, you must apply the policies.

***Q.** We live in a small town, and most of the community knows each other. There is a physician in our hospital who sometimes requests medical records, whether he is taking care of the patient or not. Is he allowed to do this?*

A. No. Only the attending, covering, or consulting physician may have access to the patient medical record. We are responsible for protecting the confidentiality of patient information from interested third parties as well as our staff. Patients are entitled to expect confidentiality, the protection of their privacy, and the release of information only to authorized parties. These rights are further enumerated in the HIPAA regulation.

Supplemental Information Regarding Federal and New York State Health Care Fraud and Abuse Laws

I. Federal and New York State Health Care Fraud and Abuse Laws.

Both the federal and New York state governments fund health care programs that provide health benefits to qualified beneficiaries. Examples of such government health care programs include, but are not limited to, Medicare and Medicaid. To avoid waste, fraud and abuse in said programs, there are Federal and State laws designed to deter fraud and abuse some of which will be described below. In addition, Rome Memorial Hospital's specific efforts to eliminate fraud, waste and abuse and to foster compliance with all such laws are set forth in the attached Hospital Corporate Compliance Manual.

a. Federal False Claims Act, 31 UCS §§ 3729 -3733.

- i.** The False Claims Act applies to any person (or entity) who:
 - 1.** Knowingly presents, or causes to be presented, to the United States Government, a false or fraudulent claim for payment or approval;
 - 2.** Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government
 - 3.** Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
 - 4.** Has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;
 - 5.** Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
 - 6.** Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
 - 7.** Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.
- ii.** Any person who engages in any of the above conduct may have violated the False Claims Act and any such person who engages in any of the above conduct may have violated the False Claims Act and may be liable for monetary penalties and damages, depending on the circumstances surrounding the false claim(s).

- b. Program Fraud Civil Remedies Act, 31 USC §§ 3801-3812 (PFCRA).** PFCRA provides for administrative remedies against any person who knowingly makes a claim or statement that the person knows or has reason to know is false, fictitious or fraudulent. The presence of a false claim is not required: a false statement is enough to trigger remedies under PFCRA.

- c. **Qui Tam Lawsuits.** The federal False Claims Act also provides for *qui tam* lawsuits through which any person (the “qui tam relator”) may bring a civil action for himself or herself and on behalf of the US Government for any violation of the False Claims Act. If the qui tam relator ultimately wins the lawsuit or if there is a settlement of the lawsuit, he or she may share in a portion of any money recovered with the government and receive reimbursement for reasonable expenses, reasonable attorneys’ fees and costs. Please note recovery by the qui tam relator is uncertain and dependent upon the facts and circumstances of the case.
- d. **New York State Social Services Law § 145-b: False Statements.**
- i. Under New York Social Services Law § 145-b, it is unlawful for any person, firm or corporation to knowingly by means of a false statement or representation (defined below), or by deliberate concealment of any material fact, or other fraudulent scheme or device, on behalf of himself/herself or others, to attempt to obtain or to obtain payment from public funds for services or supplies furnished or purportedly furnished under the Social Services Law, including Medicaid.
 - ii. "Statement or representation" includes, but is not limited to: a claim for payment made to the state, a political subdivision of the state, or an entity performing services under contract to the state or a political subdivision of the state; an acknowledgment, certification, claim, ratification or report of data which serves as the basis for a claim or a rate of payment, financial information whether in a cost report or otherwise, health care services available or rendered, and the qualifications of a person that is or has rendered health care services.
 - iii. A person, firm or corporation has attempted to obtain or has obtained public funds when any portion of the funds from which payment was attempted or obtained are public funds, or any public funds are used to reimburse or make prospective payment to an entity from which payment was attempted or obtained.
 - iv. For violation of the law (described above in section i), the local social services district or the state shall have a right to recover civil damages equal to three times the amount by which any figure is falsely overstated or in the case of non-monetary false statements or representations, three times the amount of damages which the state, political subdivision of the state, or entity performing services under contract to the state or political subdivision of the state sustain as a result of the violation or five thousand dollars, whichever is greater. Amounts collected pursuant to a judgment under the law shall be apportioned between the local social services district and the state in accordance with regulations of the Department of Social Services or the Department of Health (“DOH”), as appropriate. The remedy provided shall be in addition to any other remedy provided by law.
 - v. If any Medicaid provider or supplier is required to refund or repay all or part of any payment received by such provider or supplier, such refund or repayment shall bear interest from the date the payment was made to said provider or

supplier to the date of said refund or repayment. Interest shall be at the maximum legal rate in effect on the date the payment was made to the provider or supplier.

vi. DOH Penalties.

1. DOH may require the payment of a monetary penalty as restitution to Medicaid by any person who fails to comply with the standards of Medicaid or of generally accepted medical practice in a substantial number of cases or grossly and flagrantly violated such standards and receives, or causes to be received by another person, Medicaid payment when such person knew, or had reason to know, that:
 - a. the payment involved the providing or ordering of care, services or supplies that were medically improper, unnecessary or in excess of the documented medical needs of the person to whom they were furnished;
 - b. the care, services or supplies were not provided as claimed;
 - c. the person who ordered or prescribed care, services or supplies which was medically improper, unnecessary or in excess of the documented medical need of the person to whom they were furnished was suspended or excluded from Medicaid at the time the care, services or supplies were furnished; or
 - d. the services or supplies for which payment was received were not, in fact, provided.
2. Such penalty by DOH shall be in lieu of requiring a person to refund or repay all or part of any Medicaid payment received by such person or caused to be received by another person as a result of a violation of the terms of this subdivision. In no event shall the monetary penalty imposed exceed two thousand dollars for each item or service which was the subject of the determination, except that where a penalty has been imposed on a person within the previous five years, such penalty shall not exceed seven thousand five hundred dollars for each item or service. Any penalties collected shall be apportioned between the local social services district and New York State in accordance with DOH regulations.

II. Employee Whistleblower Protection Rights.

- a. **Hospital's Non-Retaliation Policy.** As set forth in greater detail below, the False Claims Act forbids retaliation by an employer against an employee who cooperates with investigators regarding potential False Claims Act violations or who commences qui tam actions in good faith. In accordance with such laws and its Corporate Compliance Program, Rome Memorial Hospital fully complies with all applicable "whistle-blower" protections.
- b. **Specific False Claims Act Protection.** The False Claims Act specifically provides that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employer or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False

Claims Act, shall be entitled to all relief necessary to make the employee whole. Such relief may include reinstatement with the same seniority status the employee would have enjoyed but for the discrimination; two times the amount of back pay; interest on back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

III. Hospital's Policies and Procedures to Detect and Prevent Health Care Fraud, Waste and Abuse.

For a full description of Rome Memorial Hospital's policies and procedures designed to detect and prevent health care fraud, waste and abuse, please refer to Attachment B for a listing of the Hospital's Corporate Compliance Program Policies.

Corporate Compliance Program Policies

Policy #

1	Antitrust and Trade Laws	<u>CC-001</u>
2	Business and Financial Record Integrity	<u>CC-002</u>
3	Confidential/Proprietary Business Information	<u>CC-003</u>
4	Fraud & Abuse	<u>CC-004</u>
5	Legal Compliance and Cooperation with Authorities	<u>CC-005</u>
6	Lobbying/Political Activity	<u>CC-006</u>
7	Not-For-Profit Tax-Exempt Status	<u>CC-007</u>
8	Physician Relations	<u>CC-008</u>
9	Reports of Suspected or Actual Violations of Corporate Compliance Program	<u>CC-009</u>
10	Responding to Reports of Potential or Actual Violations	<u>CC-010</u>
11	Standards of Conduct	<u>CC-011</u>
12	Government Investigation Reporting and Response	<u>CC-012</u>
13	Cost Reports	<u>CC-013</u>
14	Courtesy Discounts	<u>CC-014</u>
15	Claim Development and Submission Process	<u>CC-015</u>
16	Medical Necessity	<u>CC-016</u>
17	Written Scripts	<u>CC-017</u>
18	Excluded Provider	<u>CC-018</u>
19	New Service Development	<u>CC-019</u>
20	Compliance Education	<u>CC-020</u>
21	Whistle Blowers Provision	<u>CC-021</u>
22	Risk Assessments, Internal Auditing, Monitoring and Resolution	<u>CC-022</u>

Reporting and Response Protocol:

As part of its Corporate Compliance Program, Rome Memorial Hospital (RMH) has developed and publicized a reporting system whereby employees, physicians and agents can pose compliance-related questions and/or report perceived "Non-Compliance" by others within the organization confidentially without fear of retribution or adverse consequences. Non-Compliance is defined as failure to comply with applicable federal and state laws, and requirements of federal and state health programs (including, but not limited to Medicare and Medicaid Assistance laws, regulations and various interpretations which apply to RMH).

This reporting and response protocol outlines the process RMH will follow in responding to incidents of Non-Compliance detected through its report system.

I. Organizational Response

Employee Reporting of Potential Incidents of Non-Compliance

All employees, physicians and agents are encouraged to promptly report all instances of perceived Non-Compliance for which there is a reasonable indication that Non-Compliance has occurred.

Subsequently, RMH will promptly investigate reports received in a thorough manner. All records and any subsequent investigation of reported matters shall be retained by the Corporate Compliance Officer in confidence until such time that the investigation may require disclosure of the reporting person.

The following reporting options are available to all employees, physicians and agents:

A. Complete a written Report of Potential Non-Compliance. Once the report form or written statement is completed it should be forwarded directly to the Corporate Compliance Officer; or

B. Call RMH's Compliance Hotline (315) 338-7625 to pose a compliance-related question and/or report any potential incident which will be followed up by the Corporate Compliance Officer and/or a member of the Management Compliance Committee; or

RMH's Compliance Hotline is available to employees, physicians and agents 24 hours a day. Reports made to the Compliance Hotline are confidential. The Hotline also serves as a help-line for employees, physicians and agents to pose questions regarding billing and other compliance issues. The Corporate Compliance Officer will acknowledge questions/reports within 10 business days or less.

C. Contact the Corporate Compliance Officer or a member of the Management Compliance Committee directly by phone or schedule an appointment to pose a compliance-related question and/or report any potential incident.

Notification of Legal Counsel & Identification of Designee:

In all cases, a Report of Potential Non-Compliance will be completed and forwarded promptly to the Corporate Compliance Officer. The reports received, by their nature, will encompass varying degrees of severity. It is the Corporate Compliance Officer's responsibility to rank each incident as to the priority in which it will be handled. In certain instances, there may be vague reports made that lead to more questions. In these situations, some further inquiry and/or research must be done as a follow-up to determine if a serious matter exists. There will also be instances where an assertion of wrongdoing is supported by evidence but is not confirmed. At this time the Corporate Compliance Officer and/or a member of the Management Compliance Committee will review available evidence to determine the severity of the issue and the extent of further investigation deemed necessary, if any.

In cases where the issue raised is clearly an instance of Non-Compliance, the matter will be remedied expeditiously (for example, duplicate payment from Medicare occurred and repayment is required).

In cases where Non-Compliance is not clearly identifiable or readily confirmable, the Corporate Compliance Officer and/or a member of the Management Compliance Committee, if designated by President/CEO, will seek advice from RMH's legal counsel based on the severity of allegations.

Prior to authorizing an investigation the Corporate Compliance Officer and/or a member of the Management Compliance Committee will notify the Chief Executive Officer and Hospital Counsel when deemed necessary. When the decision is made to seek outside legal counsel, RMH's President/CEO or designee will initiate contact. Legal advice may be sought to determine the amount of RMH's liability and to determine the proper course of corrective action, disclosure responsibility and disciplinary actions, etc. Additionally, attorney-client privilege considerations will be made at this time. [The primary purpose of attorney-client privilege is to encourage full and frank communication between attorneys and their clients and thereby promote broader public interests in the observance of law and administration of justice. The major benefit of the privilege is that the person asserting it, who could be the client or the client's attorney, can refuse to disclose confidential communications that were made for the purpose of obtaining or providing legal advice.]

If an investigation is authorized by the Corporate Compliance Officer and/or a member of the Management Compliance Committee, a "Designee" to conduct the investigation will be assigned. The Designee may include but is not limited to, the Corporate Compliance Officer, legal counsel, external consultant(s), or other individuals from within the organization.

Notifying the President/CEO:

The Corporate Compliance Officer and/or the Designee will inform the President/CEO of the nature of the investigation. Corporate Compliance Officer's duty is to inform the President/CEO that an investigation has been initiated.

Once notice has been given to the President/CEO and VP/Hospital Counsel, the investigation will be conducted according to the Investigation Protocol outlined in Section II. However, if the President/CEO objects to the investigation, the Corporate Compliance Officer and/or a member of the Management Compliance Committee has the authority to unilaterally commence an investigation. The Corporate Compliance Officer would notify the Compliance Committee of the Board of Trustees in a timely manner.

II. Investigational Protocol

The Investigational Protocol ensures potential incidents reported to the Corporate Compliance Officer and/or a member of the Management Compliance Committee are investigated using a consistent methodology to verify facts and findings.

Interview of Complainants:

Once an investigation has been authorized, the Designee will conduct an interview of the complainant(s) and obtain written statements. The interview(s) are followed by a review of the applicable laws and regulations in order to make an initial assessment of whether Non-Compliance has occurred. If the findings from the interview process clearly do not support the complaint, then the case may be closed.

If the findings from the interview do support the complaint, further steps will be taken to obtain additional evidence to verify the factual information in order to confirm that Non-Compliance has occurred. In general, the investigation will include determining the nature, scope and frequency of Non-Compliance activity, as well as the financial impact, if any. This may include conducting additional inquiries, performing a review of the sample claims or other documents as deemed necessary to confirm whether Non-Compliance actually occurred and to

what extent. Additional inquiries may also be necessary to: clarify the responsibility of individuals involved, assess the possibility of criminal misconduct, determine the nature and extent of civil/criminal liability, etc.

While undertaking the investigation, the Designee may feel that the integrity of the investigation could be at stake because of the presence of employees under investigation. In these instances, the individuals should be removed from their current work activity until the investigation is finalized (unless an internal or governmental led undercover operation is in effect). The Designee should also take sound measures to secure or prevent the destruction of documents or other evidence germane to the investigation.

Investigation Report:

The Investigation will be documented in an Investigation Report which will be prepared by the Designee and will contain the following:

- Documentation of the alleged violation;
- A description of the interview process;
- Copies of the interview notes and key documents
- A log of the witnesses interviewed and the documents reviewed; and
- The results of the investigation including any disciplinary action taken and the course of corrective action implemented or to be implemented

The Corporate Compliance Officer should also consider further review of the reasons for the investigation to determine if there is a relationship with other pending matters or closed investigations.

After the Investigation Report is completed and reviewed with Internal Hospital Counsel, follow up actions will be taken according to the Follow-up Protocol outlined below in order to close the case.

III. Follow-Up Protocol

If the case involves billing Non-Compliance, and Non-Compliance is confirmed, RMH will cease billing for the services included in the investigation until corrective action can be implemented effectively. If it is determined that improper payment has been received, the appropriate repayment would be calculated and reported to external legal counsel. Legal counsel would work with RMH to notify the fiscal intermediary and return any overpayment.

If it is determined that criminal misconduct has occurred, the matter will immediately be referred to RMH's in-house and/or outside legal counsel, depending on the nature of the situation, to initiate contact to the appropriate law enforcement agency.

RMH will adhere to the following reporting requirements:

If the Corporate Compliance Officer, Management Compliance Committee or Designee discovers credible evidence of misconduct from any source and, after a reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then the hospital promptly will report the existence of misconduct to the appropriate governmental authority, which may include the fiscal intermediary, within a reasonable period after determining that there is credible evidence of a violation. Prompt reporting will demonstrate the RMH's good faith and willingness to work with authorities to correct and remedy the problem. When reporting misconduct to the Government, the Hospital will provide that information which, under advice of counsel, it deems necessary. The Corporate Compliance Officer, under advice of counsel, and with guidance from the authorities, may be requested to continue to investigate the reported violation. Once the investigation is completed, the Compliance Officer may notify the appropriate authority of the outcome of the investigation, including a description of the impact of the alleged violation of the operation of the applicable health care

programs or their beneficiaries. If the investigation ultimately reveals that criminal or civil violations have occurred, the appropriate federal and state officials (¹) should be notified within a reasonable period of time.

As previously stated, RMH shall take appropriate corrective action, including prompt identification and restitution of any overpayment to the affected payor and the imposition of proper disciplinary action. Recognizing that failure to repay overpayments within a reasonable period of time could be interpreted as an intentional attempt to conceal the overpayment from the Government, thereby establishing an independent basis for a criminal violation with respect to RMH, as well as any individuals who may have been involved, overpayments obtained from Medicare or other federal health care programs shall be promptly returned to the payor that made the erroneous payment.

The Corporate Compliance Officer, Management Compliance Committee or Designee is responsible for determining if there is "credible evidence" of misconduct. The Compliance Officer may consult with other Hospital officials in making a determination such as the VP Human Resources.

If the incident requires disciplinary action, the discipline process will proceed per RMH policy. The Corporate Compliance Officer and/or a member of the Management Compliance Committee is responsible for evaluating RMH's training and education needs and ongoing monitoring activities which will be enhanced, to the extent necessary, to prevent any reoccurrence. If there has not been an improper payment and disciplinary action is not warranted, training and education may still be necessary so as to prevent any reoccurrence.

The Corporate Compliance Officer is responsible for determining when the case is closed. This determination is a matter of judgment based on the facts and circumstances of each case. In all cases where the identity of the complainant is known, the complainant will be notified in writing upon closing of the case.

¹Appropriate federal and state authorities include the Criminal and Civil Divisions of the Department of Justice, the U.S. Attorney in the Hospital's district, and the investigative arms for the agencies administering the affected federal or state health care programs, such as the New York Medicaid Fraud Control Unit, the Defense Criminal Investigative Service, and the Offices of Inspector General of the Department of Health and Human Services, the Department of Veterans Affairs and the Office of Personnel Management (which administers the Federal Employee Health Benefits Program).

APPENDIX 1

The Management Compliance Committee includes but is not limited to:

President/Chief Executive Officer
Vice President / Clinical Services
Administrator RHCF
Vice President and Chief Quality Officer
Chief Medical Officer
Chief Financial Officer
Vice President/Chief Information Officer
VP Human Resources
Corporate Compliance Officer and Privacy Officer
Controller
Director of Medical Imaging
Director of Business Office
Director Patient Access
Director of Medical Records
Director of Laboratory Services
Practice Administrator