Title: Compliance Plan and Code of Conduct			**Policy #:** CP001
Type: Compliance	**Effective Date:** 9/3/21		**Board Approval Date: 9/3/21**
Revised Dates:			

Contents

I. **Policy**

It is the policy of Finger Lakes Independent Provider Association (FLIPA) to develop, maintain, and update as appropriate a written Compliance Plan and Code of Conduct to provide employees, Board members, vendors and contracted staff with guidance on requirements for conduct related to employment or engagement by FLIPA.

The Code of Conduct describes important parts of the compliance program including, but not limited to the problem resolution process, compliance hotline, and non-retaliation policy.

All employees, Board members and contracted staff will be provided a copy of the Code of Conduct and Compliance Plan upon hire/engagement/association and upon substantial revision. The Code of Conduct and Compliance Plan will be readily available to associated individuals by request or on FLIPA's Teams Channel.

II. **Procedures**

A. Development and Oversight

1. The Compliance Officer is responsible for the development and periodic update of FLIPA's Compliance Plan and the FLIPA Code of Conduct.
2. The Board of Directors is responsible for oversight of the Compliance Plan and the Code of Conduct.
3. The Code of Conduct document is written at a basic reading level, avoiding complex language and legal terminology. At a minimum, it addresses critical areas such as compliance with laws and regulations, human resource practices, quality of care/service, conflicts of interest, proprietary rights, confidentiality, safety, and reimbursement practices.

B. Content

1. The Code of Conduct addresses major issues identified by the Federal Sentencing Guidelines, the Office of Inspector General (OIG) and the New York State Medicaid Inspector General (OMIG).
2. The Code of Conduct addresses human resources related compliance issues such as sexual harassment and discrimination, as well as FLIPA's commitment to quality service.
3. Both the Compliance Plan and Code of Conduct include instructions on how to report fraud, waste and abuse, suspected violations or other suspected wrongdoing

C. Distribution

1. FLIPA's Compliance Plan, applicable policies, and the Code of Conduct will be available to all Board members, employees, and contracted staff. It will be available on the FLIPA intranet. All employees, Board Members and contracted staff will acknowledge: (a) having available a copy of the Compliance Plan and Code of Conduct, (b) reading and understanding the contents, and (c) agreeing to abide by the

provisions of the documents. Information about the Plan and the Standards of Conduct will be available on the FLIPA website.

2. The Compliance Officer will ensure that sign off records are maintained.
3. The Compliance Officer will ensure that each Board member is provided with a copy of the Compliance Plan and the Code of Conduct at the time of Board Orientation and upon any significant revision.
4. The Compliance Officer will ensure that all contracted staff are provided with a copy of the Compliance Plan and Code of Conduct upon entering into a contractual agreement with FLIPA.
5. The Compliance Officer will include in his or her report to the Compliance Committee and Board of Directors the status of training, along with any recommendations for updating or improving the contents of the Compliance Plan or the Code of Conduct.

D. Violations

1. The Compliance Officer is responsible for investigations of possible violations of Compliance Plan and/or Code of Conduct and, in conjunction with Human Resources, assuring disciplinary action is taken when necessary.

Title:	Conflicts of Interest			**Policy #:**	CP002
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. **Policy**

It has been and shall continue to be the policy of the Finger Lakes Independent Provider Association (FLIPA) that all members of the Board of Directors, Officers, and any Employees of FLIPA, avoid any conflict, or appearance of conflict, between their personal or other interests and the interests of FLIPA in dealing with any organization or individual having, or seeking to have, any business relationship with FLIPA or with any organization or individual whose objectives or interests may be adverse to FLIPA interests. This policy is intended to supplement but not replace any applicable state and federal laws governing Conflicts of Interest applicable to nonprofit and charitable organizations.

The Board of Directors of FLIPA will oversee, implement, and enforce this policy.

II. **Procedures**

A. Duty to Disclose

All Interested Persons shall disclose any possible Conflict of Interest at the earliest practicable time to the Board of Directors.

B. Recusal of Self

No Officer, Director or Employee shall comment on any matter under consideration at a Board of Directors meeting, in which such individual has a possible Conflict of Interest, before giving notice to the Board of Directors of the possible Conflict of Interest, and allowing it to consider whether a conflict exists. The individual is under an affirmative duty to inform FLIPA of any reasons unknown to FLIPA, or not fully appreciated by FLIPA, as to why the matter may not be in the best interest of FLIPA.

C. Determining Whether a Conflict of Interest Exists

After disclosure of the Financial Interest or other potential interest along with all material facts, and after any discussion with the Interested Person, he/she shall leave the Board of Directors meeting while the determination of a Conflict of Interest is discussed and voted upon. The remaining members of the Board of Directors shall decide if a Conflict of Interest exists.

D. Addressing the Conflict of Interest

1. If the Board (or a committee of the Board) determines that an Interested Person has a Conflict of Interest with respect to a matter coming before the Board (or the committee), such Interested Person may not be present at or participate in deliberations post motion or vote on such matter. However, if requested by the Board (or the committee) such Interested Person may make a presentation to the Board (or the committee) as background and answer questions prior to commencement of deliberations by the Board (or the committee). Such Interested Person shall leave the meeting following such presentation and before motion and deliberations begin and a vote is taken.
2. The Chair of the Board of Directors shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

3. After exercising due diligence, the Board of Directors shall determine whether FLIPA can obtain with reasonable efforts a more advantageous transaction or arrangement from a person or entity that would not give rise to a Conflict of Interest.

4. If a more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a Conflict of Interest, the Board of Directors shall determine by a majority vote of the disinterested trustees whether the transaction or arrangement is in FLIPA's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination, it shall make its decision as to whether to enter into the transaction or arrangement.

E. Consequences for Failure to Disclose a Possible Conflict of Interest

1. If the Board of Directors has reasonable cause to believe an Officer, Director, or Employee has failed to disclose an actual or possible Conflict of Interest, it shall inform the individual of the basis for such belief and afford the individual an opportunity to explain the alleged failure to disclose.

2. If, after hearing the Officer, Director, or Employee's response and after conducting a further investigation as warranted by the circumstances, the Board of Directors determines the individual has failed to disclose an actual or possible Conflict of Interest, it shall take appropriate disciplinary and corrective action.

F. Documentation of Proceedings

The minutes of the Board of Directors and all committees with delegated powers shall contain:

1. The names of the persons who disclosed or otherwise were found to have a Financial Interest in connection with an actual or possible Conflict of Interest, the nature of the financial or other interest, any action taken to determine whether a Conflict of Interest was present, and the Board of Directors' decision as to whether a Conflict of Interest in fact existed.

2. The names of the persons who were present for discussions and votes relating to the transactions or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

G. Annual Statements and Periodic Review

1. In addition to the immediate disclosure of possible conflicts as they arise, prior to the initial election or appointment of any Officer, Director, or Employee (Covered Individuals), and annually thereafter, such Officer, Director, or Employee shall complete, sign and submit to the Secretary of FLIPA a written statement identifying, to the best of the individual's knowledge, any entity of which such individual is an officer, trustee, member, owner (either as a sole proprietor or a partner), or employee, which FLIPA has a current relationship with, as well as any transaction in which FLIPA is a participant and in which the individual might have a conflicting interest.

2. Each Officer, Director and Employee shall complete and file with the Secretary of FLIPA annually each year, information about possible beneficial or adverse interests affecting FLIPA, including interests of relatives[1] and organizations in which the Covered Individual (or relative) has a significant management function[2] or a significant ownership interest.[3] The information shall include any gifts of more than nominal value ($75.00 USD) received by FLIPA Covered Individual from suppliers of goods or services, or from students, faculty, or others associated with or seeking association with FLIPA.

3. Each Director, Officer and Employee of FLIPA shall annually sign a statement which affirms such person:

   a) Has received a copy of this Conflict of Interest policy;

   b) Has read and understands the policy;

   c) Has agreed to comply with the policy; and

   d) Understands FLIPA is not-for-profit and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

4. If at any time during the year, the information in the annual statement changes materially, the Director, Officer, or Employee shall disclose such changes and review the annual disclosure form.

5. The Secretary of FLIPA shall provide a copy of all completed annual statements to the Chair of the Board of Directors.

6. The Board of Directors shall regularly and consistently monitor and enforce compliance with this policy by reviewing annual statements and taking such other actions as are necessary for effective oversight.

7. To ensure FLIPA operates in a manner consistent with purposes and does not engage in activities that could jeopardize its tax-exempt status, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, including the following subjects:

   a) Whether compensation arrangements and benefits are reasonable, based on competent survey information (if reasonably available), and the result of arm's length bargaining.

   b) Whether partnerships, joint ventures, and arrangements with management organizations, if any, conform to FLIPA's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, further charitable purposes and do not result in inurement or impermissible private benefit or in an excess benefit transaction.

8. When conducting the periodic reviews as provided for above, FLIPA may, but need not, use outside advisors. If outside advisors are used, their use shall not relieve the Board of Directors of its responsibility for ensuring periodic reviews are conducted.

H. Prohibitions of Individuals with a Conflict of Interest

It is a violation of this policy:

1. For any person with a Conflict of Interest to improperly influence the deliberation or voting on the matter giving rise to such conflict by the Board of Directors.
2. For any person with a Conflict of Interest to be present at or participate in deliberations or voting on the matter giving rise to a Conflict of Interest before the Board of Directors.
3. For any new Officer, Director, or Employee to fail to complete the disclosure form, attached as Attachment A, prior to his or her election or appointment.
4. For any Officer, Director, or Employee to fail to annually complete the disclosure form Attachment A on a yearly basis or when circumstances change.

III. Definitions

Conflict of Interest: An Officer, Director, or Employee shall be considered to have a possible Conflict of Interest if: (a) such individual has an existing or potential financial or other interest which impairs or might appear to impair such person's independent unbiased judgment in the discharge of his or her responsibilities to FLIPA; (b) such individual is aware that a relative or any organization in which such member (or relative[1]) has a significant management function[2] or ownership interest,[3] has such existing or potential financial or other interest; (c) such individual (or relative) has a significant business relationship with any person or firm engaging in, or seeking to engage in, business with FLIPA, in a matter brought to the attention of FLIPA; or (d) such individual, a relative, or an organization in which the person or relative has a significant ownership interest, management function, or other material interest, may receive a material financial or other benefit from the knowledge or information confidential to FLIPA.

The following are examples of potential Conflicts of Interest that may arise between FLIPA and its Officers, Directors, and Employees. This list is not a list of all Conflicts of Interest, but is being provided for illustrative purposes only:

- The Executive Director hires a relative to provide printing services to FLIPA.
- A member of the Board of Directors accepts fees and provides advice to a company that is a vendor of FLIPA.

Financial Interest: A person has a Financial Interest if the person has, directly or indirectly, through business, investment, or relative:

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[1] Relatives include a spouse/domestic partner, parent (biological, adoptive, in-law, step or foster), sibling (biological, adoptive, in-law, step or foster), child (biological, adoptive, step or foster), grandchild or grandparent, nieces, nephews, or other family members residing in the same household.

[2] e.g., trustee, general manager, principal officer.

[3] A significant ownership interest is 5% or more of the stock in a corporation doing business with FLIPA, 5% or more interest in the profits of a partnership or a general partner in a partnership doing business with FLIPA, or a beneficial interest of 5% or more in any other enterprise doing business with FLIPA.

- An ownership or investment interest in any entity with which FLIPA has a transaction or arrangement;
- A compensation arrangement with FLIPA or with any entity or individual with which FLIPA has a transaction or arrangement; or
- A potential ownership or investment interest in, or compensation with, any entity or individual with which FLIPA is negotiating a transaction or arrangement.
    - Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial.
    - A Financial Interest is not necessarily a Conflict of Interest. A person who has a Financial Interest may have a Conflict of Interest only if the Board of Directors decides that a Conflict of Interest exists, in accordance with this policy.

Interested Person: Any director, officer, member of a committee with governing board delegated powers, or Employee of FLIPA, who has a direct or indirect Financial Interest.

IV. **Attachments**

- Attachment A: *Director, Officer, Employee Annual Conflict of Interest Statement and Acknowledgment*

Attachment A

Of CP002: Conflicts of Interest

Conflicts of Interest
Statement and Acknowledgment

1. Are you an officer, director, member, owner (either as a sole proprietor or a partner), or employee of an entity with which Finger Lakes Independent Provider Association (FLIPA) has a relationship? _____

   If yes, what is the name of the entity and the nature of the relationship?

2. To the best of your knowledge, are aware of any transaction in which FLIPA is or is planning to be a participant and in which you might have a conflicting interest? _____

   If yes, has the conflicting interest been disclosed, as provided in the Conflicts of Interest Policy?

By signing this Acknowledgement, I affirm that I have received a copy of FLIPA Conflict of Interest Policy, and that I have read, understand, and agree to comply with the Policy. I understand that FLIPA is a not-for-profit corporation and that in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more tax-exempt purposes. I further acknowledge that I have answered the above questions accurately and to the best of my knowledge.

Director, Officer, Employee:

_____ _____

Name (please print) **Signature**

Title: _____ **Date:** ____/____/____

FLIPA Secretary:

_____ **Date:** ____/____/____

Signature

Title:	Exclusion Screening			**Policy #:**	CP003
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) not to employ, contract with, or conduct business with an individual or entity excluded from participation in federally sponsored health care programs, such as Medicare and Medicaid.

II. Procedures

A. Notification

1. It is the policy of FLIPA that employees, board members, and contracted staff have an affirmative responsibility to notify the Compliance Officer promptly if charged with a criminal offense related to health care or is proposed or found to be subject to exclusion from federal healthcare programs.

B. Employees, Partners, Board Members, Contracted Staff and Vendors

1. FLIPA will conduct exclusion checks to verify that all employees, partners, board members, vendors and contracted staff have not been excluded from federal or state

healthcare programs. An exclusion check is a search of the following sources to determine if the individual or entity's name appears on any of the lists:

a) U.S. Department of Health and Human Services, Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) available on the website athttps://oig.hhs.gov/exclusions/.

b) The System for Award Management's (SAM) Excluded Parties List available on the website at https://sam.gov/content/exclusions.

c) For New York State Agencies: the NYS Medicaid Fraud Database available on the NYS Office of the Medicaid Inspector General website at https://apps.omig.ny.gov/exclusions/ex_search.aspx.

C. Frequency

1. An exclusion screen will be performed

a) On all applicants for employment as part of the pre-employment screening process. If the exclusion check indicates that any individual has been excluded from federal or state healthcare programs, the applicant will not be offered employment.

b) For potential board members as part of the initial screening process. If the exclusion check indicates that a potential board member has been excluded from federal or state healthcare programs, the individual will not be considered for board affiliation.

c) For potential partners, vendors and contracted staff as part of the initial screening process. If the exclusion check indicates that a potential vendor or contractor has been excluded from federal or state healthcare programs, the entity will not be contracted with.

d) The Compliance Officer will ensure that exclusion screening is conducted on all existing employees, partners, board members, vendors and contracted staff at least monthly.

D. Positive Exclusion Screen Result

1. If any FLIPA employee, partner, board member, vendor or contractor is charged with a criminal offense related to healthcare or is proposed or found to be subject to exclusion from federal healthcare programs, the employee, individual or entity must be removed from direct responsibility or involvement in any federally funded healthcare program while the matter is pending. If the matter results in conviction or exclusion, FLIPA will immediately terminate the affiliation with FLIPA.

III. **References**

- Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs Issued May 8, 2013
- Section 1156 of the Social Security Act
- Section 1128 of the Social Security Act
- 18 NYCRR §515.3
- 18 NYCRR §515.7

Title:	Compliance Training			**Policy #:**	CP004
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Compliance and Privacy Officer Melissa Zambri	**Signature:**	**Date:**
Executive Director Patricia McMahon	**Signature:**	**Date:**

Contents

I. **Policy**

It is the policy of Finger Lakes Independent Provider Association (FLIPA) that all employees, Board members, and contracted staff receive annual training related to the organization's overall Compliance Plan.

Participation in compliance training sessions is mandatory and for employees is a condition of continued employment.

II. **Procedures**

A. Development and Monitoring

1. The Compliance Officer is responsible for developing the compliance education curriculum and monitoring and ensuring that compliance training and orientation meet the policy standards on this subject.

B. Frequency

1. Compliance training is included as part of the orientation for all employees, applicable contractors and Board Members. Training for employees and volunteers will be provided within 30 days of hire or other association with FLIPA and at least annually thereafter. Governing body members will be trained within ninety (90) days of appointment. Contractors will receive materials about the Compliance Program and will be required to agree to contractual language regarding its review and understanding of the same.
2. All existing employees, applicable contractors and Board Members are required to complete compliance training at least once per year.
3. Employees, Partners, applicable contractors and Board Members are provided with the opportunity to seek clarification or more information on any aspect of the Compliance Plan.

C. Content

1. Comprehensive training materials facilitate the training and ensures that a consistent message is delivered.
2. Compliance training as a part of orientation includes, at a minimum:
   a) An introduction to the FLIPA Compliance Plan and its objectives;
   b) A written copy of the Code of Conduct and Compliance Plan; and
   c) Instructions on accessing compliance policies.
3. Annual compliance training includes, at a minimum:
   a) An explanation of the structure and operation of the Compliance Plan, including information on the following:

(1) Code of Conduct and other related written guidance;
(2) Applicable policies and procedures;
(3) False Claims Act;
(4) Whistleblower Provisions;
(5) New York State False Claims Act;
(6) Risk Areas;
(7) The role of the Compliance Officer and Compliance Committee;
(8) Communication channels (name of Compliance Officer, reporting mechanisms, hotline);
(9) Organizational expectations for reporting problems and concerns;
(10) Non-retaliation policy;
(11) Any changes in federal or state regulations;
(12) Disciplinary standards;
(13) Response to compliance concerns and corrective action plans;
(14) Information regarding the requirements of the Medicaid program related to the employee, volunteer or contractor;
(15) Claims submission and billing requirements best practices;
(16) Compliance as a condition of employment and/or business relationship.

b) Any changes in federal or state regulations

D. Specialized Training

1. Those in identified risk areas will receive more detailed education related to their function and responsibilities.
2. The Compliance Officer is responsible for coordinating with management to ensure that specialized compliance education occurs in identified risk areas.
3. Managers shall assist the Compliance Officer in identifying areas that require specific training and are responsible for communication of terms of the Compliance Plan.
4. Specialized areas for education may include, but are not limited to, the following:
   a) HIPAA Privacy Rule;
   b) Preparation of reports;
5. Additionally, FLIPA will ensure that the Compliance Officer has sufficient opportunities to receive training related to the compliance industry.

E. Acknowledgment Form

1. Each new employee, Board member, and applicable contractor will sign an *Onboarding Training Acknowledgment* (Appendix A), which includes an acknowledgment that that he/she understands and will comply with the Compliance Plan and Code of Conduct.
2. Each year, existing employees, Board members and contracted staff will complete the acknowledgment electronically which will be stored on FLIPA's server.

F. Tracking and Reporting

1. All training participation relating to the Compliance Plan is tracked.
2. Training records are maintained.
3. The Compliance Officer is responsible for submitting periodic reports to the Board of Directors related to training on the compliance program.

III. **Attachments**

- Attachment A: *Onboarding Training Acknowledgment*

Attachment A

of CP004: Compliance Training

Onboarding Training Acknowledgment

Topics Covered

- Code of Conduct and other related written guidance;
- Applicable policies and procedures;
- False Claims Act;
- Whistleblower Provisions;
- New York State False Claims Act;
- Risk Areas;
- The role of the Compliance Officer and Compliance Committee;
- Communication channels (name of Compliance Officer, reporting mechanisms, hotline);
- Organizational expectations for reporting problems and concerns;
- Non-retaliation policy;
- Any changes in federal or state regulations;
- Disciplinary standards;
- Response to compliance concerns and corrective action plans;
- Information regarding the requirements of the Medicaid program related to the employee, volunteer or contractor;
- Claims submission and billing requirements best practices;
- Compliance as a condition of employment and/or business relationship.

I acknowledge that:

- ✓ I have completed the FLIPA Onboarding Training according to the date signed below. I have been provided with the opportunity to ask any questions that I may have.
- ✓ I have received and read a copy of the Compliance Plan and Code of Conduct.

I understand that:

- ✓ I must comply with the Compliance Plan, Code of Conduct, all laws, regulations, policies and procedures, and guidance provided.
- ✓ I must report any instances of possible violations of the Compliance Plan, Code of Conduct, laws, regulations, and policies and procedures to a member of management or the Compliance Officer.
- ✓ FLIPA maintains a hotline for confidential or anonymous reporting of possible violations of the Compliance Plan, Code of Conduct, laws, regulations, and policies and procedures.
- ✓ My failure to comply with the Compliance Plan, Code of Conduct, laws, regulations, and policies and procedures, or to report possible violations may result in disciplinary action, up to and including termination.

Name (please print)	**Signature**
Title:	**Date:** / /

Title:	Enforcement of Compliance Standards			**Policy #:**	CP005
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) that employees, contractors and others who are affiliated with FLIPA, who upon investigation are found to have committed violations of applicable laws and regulations, the Compliance Plan, the Code of Conduct, or FLIPA policies and procedures will be subject to appropriate disciplinary action, up to and including termination of employment, contract or other affiliation with FLIPA.

II. Procedures

A. Documentation

1. Discipline will be appropriately documented in the disciplined employee's personnel file along with a written statement of reason(s) for imposing such discipline.
2. Discipline for contractors will be documented in the contractual record for the disciplined contractor.
3. Discipline for others affiliated individuals will be handled and documented by the Executive Director except for Board matters which shall be handled under the Board's Bylaws.

B. Consistency

1. The Compliance Officer and Human Resources personnel will be responsible for ensuring that disciplinary actions related to non-compliance are consistent with

actions taken in similar instances of non-compliance and across all levels of personnel, except for those related to Board Members which will be addressed under the Bylaws.

2. FLIPA shall apply discipline consistent with the violation. Examples of the disciplinary action that may be taken in accordance with the nature and scope of the infraction include but are not limited to:
   a) verbal counseling or warning;
   b) counseling with written warning;
   c) retraining;
   d) reassignment or demotion;
   e) suspension without pay; and
   f) termination of employment, contract or other association with FLIPA.
3. The Compliance Officer will reference the record of disciplinary actions as necessary to ensure consistency in the application of disciplinary measures related to compliance violations.

C. Examples of Compliance Violations

1. Authorization of or participation in actions that violate law, regulations, and other obligations related to FLIPA, the Compliance Plan, including the Code of Conduct, and all related policies and procedures;
2. Failure to comply with FLIPA policies governing the prevention, detection, or reporting of fraud and abuse or other compliance issues;
3. Failure to report a violation under this policy or any other policy which mandates reporting at the Agency;
4. Failure to cooperate in an investigation; or
5. Retaliation against an individual for reporting a possible violation or participating in an investigation.

D. Determination

1. When the determination is made that a compliance violation has occurred, the Compliance Officer will notify the Executive Director and the individual's manager. If appropriate, the Compliance Officer may notify the Board of Directors before the next regularly scheduled meeting when a full report of compliance-related disciplinary actions would normally be presented.
2. The Compliance Officer and Human Resources personnel, unless implicated, shall work in collaboration with the appropriate manager in determining disciplinary action related to an instance of non-compliance. Where implicated, the Executive Director would replace the individual implicated. The Compliance Officer or Executive Director as appropriate shall have the discretion to recommend a disciplinary process other than the normal procedure.

Title:	False Claims Act and Whistleblower Protections			**Policy #:**	CP006
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) to comply with all Federal and State regulations as it pertains to False Claims and Whistleblower protections.

This Policy explains the Federal False Claims Act (31 U.S.C. §§ 3729 - 3733), the Administrative Remedies for False Claims (31 USC Chapter 38 §§3801-3812), the New York State False Claims Act (State Finance Law §§187-194), and other New York State laws concerning false statements or claims and employee protections against retaliation. This policy also sets forth the procedures that FLIPA has put into place to prevent any violations of Federal or New York State laws regarding fraud or abuse in its health care programs.

II. Procedures

A. Employees, Contractors and Partners

1. For purpose of this policy, a contractor or partner is defined as:

a) Any contractor, subcontractor, partner, or other person who, on behalf of FLIPA, furnishes or otherwise authorizes the furnishing of Medicare and/or Medicaid health care items or services, or performs billing or coding functions; or

b) Any contractor, subcontractor, partner, or other person who provides administrative or consultative services, goods or services that are significant and material, are included in or are a necessary component of providing items or services.

B. Training

1. FLIPA will provide training/education of this policy to all its employees, contractors, and partners. This training will be provided to all new employees and contractors as part of their orientation.

C. Reporting

1. Any employee, contractor, or partner who has any reason to believe that anyone is engaging in false reporting practices or false documentation of services is expected to report the practice in accordance with CP007 -Reporting of Compliance Concerns and Non-Retaliation Policy.

D. Non-Retaliation

1. Any form of retaliation against any employee who reports a perceived problem or concern in good faith is strictly prohibited.

2. Any employee, contractor or partner who commits or condones any form of retaliation will be subject to discipline up to, and including, termination of employment or contract.

E. The False Claims Act (31 U.S.C. §§ 3729-3733)

1. The False Claims Act is a Federal law designed to prevent and detect fraud, waste, and abuse in Federal healthcare programs, including Medicaid and Medicare. Under the False Claims Act, anyone who "knowingly" submits false claims to the Government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties of $10,781 to $21,563 (which increases with inflation) per claim for each false claim submitted.

2. The law was revised in 1986 to expand the definition of "knowingly" to include a person who:

a) Has actual knowledge of falsity of information in the claim;

b) Acts in deliberate ignorance of the truth or falsity of the information in the claim; and

c) Acts in reckless disregard of the truth or falsity of the information in a claim.

3. False Claims suits can be brought against individuals and entities. The False Claims Act does not require proof of a specific intent to defraud the Government. Individuals can be prosecuted for a wide variety of conduct that leads to the submission of a false claim. Some examples include:
    a) Knowingly making false statements;
    b) Falsifying records;
    c) Submitting claims for services never performed or items never furnished;
    d) Double-billing for items or services:
    e) Using false records or statements to avoid paying the Government;
    f) Falsifying time records used to bill Medicaid; or
    g) Otherwise causing a false claim to be submitted.
4. Whistleblower or "Qui Tam" Provisions
    a) In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act contains a "Qui Tam" or whistleblower provision.
    b) The Government, or an individual citizen acting on behalf of the Government, can bring actions under the False Claims Act. An individual citizen, referred to as a whistleblower or "Relator" who has actual knowledge of allegedly false claims may file a lawsuit on behalf of the U.S. Government. If the lawsuit is successful, and provided certain legal requirements are met, the whistleblower may receive an award ranging from 15% - 30% of the amount recovered.
5. Employee Protections
    a) The False Claims Act prohibits discrimination by FLIPA against any employee for taking lawful actions under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in False Claims actions is entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay, and compensation for any special damages, including litigation costs and reasonable attorney fees.
6. Administrative Remedies for False Claims (31 USC Chapter 38. §§3801-381 2)
    a) This Federal statute allows for administrative recoveries by Federal agencies including the Department of Health and Human Services, which operates the Medicare and Medicaid Programs. The law prohibits the submission of a claim or written statement that the person knows or has reason to know is false, contains false information or omits material information. The agency receiving the claim may impose a monetary penalty of up to $5,500 per claim and damages of twice the amount of the original claim.

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

F. New York State Laws

1. Civil and Administrative Laws

a) New York State False Claims Act (State Finance Law §§187-194)

(1) The New York State False Claims Act closely tracks the Federal False Claims Act. It imposes fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is up to $12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may be responsible for the government's legal fees.

(2) The Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the New York State False Claims Act. If the suit eventually concludes with payments back to the government, the party who initiated the case can recover 15% - 30% of the proceeds, depending upon whether the government participated in the suit. The New York State False Claims Act prohibits discrimination against an individual for taking lawful actions in furtherance of an action under the Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole.

b) Social Service Law §145-b False Statements

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

c) Social Service Law §145-c Sanctions

(1) If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's and the person's family needs are not taken into account for a period of six months to five years, depending upon the number of offenses.

2. Criminal Laws

a) Social Service Law §145 Penalties

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

b) Social Service Law § 366-b. Penalties for Fraudulent Practices

(1) Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, knowingly submits false information for the purpose of obtaining Medicaid compensation greater than that to which he/she is legally entitled to, or knowingly submits false information in order to obtain authorization to provide items or services shall be guilty of a Class A misdemeanor.

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

c) Penal Law Article 155. Larceny

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

d) Penal Law Article 175. Written False Statements

(1) There are four crimes in this Article that relate to filing false information or claims. Actions include falsifying business records, entering false information, omitting material information. altering an agency's business records or providing a written instrument (including a claim for payment) knowing that it contains false information. Depending upon the action and the intent a person may be guilty of a Class A misdemeanor or a Class E felony.

e) Penal Law Article 176. Insurance Fraud

(1) This Article applies to claims for insurance payment, including Medicaid or other health insurance. The six crimes in this Article involve intentionally filing a false insurance claim. Under this article, a person may be guilty of a felony for false claims in excess of $1,000.

f) Penal Law Article 177. Health Care Fraud

(1) This Article establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), he/she knowingly provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which he/she is not entitled. Health Care Fraud is punished with fines and jail time based on the amount of payment inappropriately received due to the commission of the crime.

g) New York Labor Law §740

(1) An employer may not take any retaliatory personnel action against an employee if the employee discloses information about the employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official.

(2) This law offers protection to an employee who:

(a) Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy, or practice of the employer that is in violation of law, rule, or regulation that presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions);

(b) Provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into any such violation of a law, rule, or regulation by the employer; or

(c) Objects to, or refuses to participate in, any such activity, policy, or practice in violation of a law, rule, or regulation.

(3) The employee's disclosure is protected under this law only if the employee first brought up the matter with a supervisor[1] and gave the employer a reasonable opportunity to correct the alleged violation. The law allows employees who are the subject of a retaliatory action to bring a suit in state court for reinstatement to the same, or an equivalent position, any lost back

[1] NYS Labor Law 740 1.(F)(1)(f) "Supervisor" means any individual within an employer's organization who has the authority to direct and control the work performance of the affected employee; or who has managerial authority to take corrective action regarding the violation of the law, rule or regulation of which the employee complains.

wages and benefits and attorneys' fees. If the employer is a health care provider and the court find that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

h) New York Labor Law §741

(1) Under this law, a health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices, or activities to a regulatory, law enforcement, or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care.

(2) The employee's disclosure is protected under this law only of the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If the employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health care provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

III. **Associated Policies**

- CP007 -Reporting of Compliance Concerns and Non-Retaliation Policy

Title:	Reporting Compliance Concerns and Non-Retaliation			**Policy #:**	CP007
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) that all Employees and Contracted Staff have an affirmative duty and responsibility for promptly reporting any known or suspected misconduct, including actual or potential violations of laws, regulations, policies, procedures, the Compliance Plan, or Code of Conduct.

II. Procedures

A. Employee and Contracted Staff

a) The "open-door policy" will be maintained at all levels of management to encourage Employees and Contracted Staff to report problems and concerns.

b) FLIPA will maintain a Compliance Hotline: (888) 808-0992. Employees and Contracted Staff may report their compliance concerns confidentially to the Compliance Officer through use of the Compliance Hotline.

c) Any form of retaliation against any employee and/or Contracted Staff who reports a perceived problem or concern in good faith is strictly prohibited.

d) Any Employee and Contracted Staff who commits or condones any form of retaliation will be subject to discipline up to, and including, termination.

e) Employees and Contracted Staff cannot exempt themselves from the consequences of their own misconduct by reporting the issue, although self-

reporting may be taken into account in determining the appropriate course of action.

f) Knowledge of misconduct, including actual or potential violations of laws, regulations, policies, procedures, or Code of Conduct, must be immediately reported to management (which includes executives, directors, and managers), Human Resources, the Compliance Officer, or the Compliance Hotline.

g) Employees and Contracted Staff have the same reporting obligations for actual or suspected violations committed by vendors or subcontractors.

h) Confidentiality will be maintained to the extent that is allowable by law. Employees and Contracted Staff should be aware that FLIPA is legally required to report certain types of crimes or potential crimes and infractions to external governmental agencies such as matters subject to a disciplinary proceeding, referred to, or under investigation by MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding. Such persons shall be protected under the FLIPA policy for non-intimidation and non-retaliation..

i) Employees and Contracted Staff may report their compliance concerns confidentially, subject to the above, to the Compliance Hotline and provide his or her identity. Callers should be aware, however, that it may not be possible to preserve anonymity if they identify themselves, provide other information that identifies them, the investigation reveals their identity, or if they inform others that they have called the Compliance Hotline.

j) If the caller wishes to make the report anonymously to the Compliance Hotline, no attempt will be made to trace the source of the call or identify of the person making the call.

k) The Compliance Hotline number will be published and visibly posted in a manner consistent with Employee and Contracted Staff notification in locations frequented by Employees and Contracted Staff.

l) FLIPA will not impose any disciplinary or other action in retaliation against individuals who make a good faith report of a potential compliance issue to appropriate personnel, participate in an investigation of a potential compliance issue, conduct or participate in internal reviews or self-evaluations, participate in audits and remedial actions, and/or report instances of intimidation and retaliation and/or report potential fraud, waste or abuse to appropriate government officials.. "Good faith" means that the individual believes that the potential violation occurred as he or she is reporting.

m) FLIPA strictly prohibits its Employees and Contracted Staff from engaging in any act, conduct, or behavior that results in, or is intended to result in retaliation against any employee and contracted Staff who makes a good faith report of a potential compliance issue to appropriate personnel, participates in an investigation of a potential compliance issue, conducts or participates in internal reviews or self-evaluations, participates in audits and remedial actions, and/or reports instances of intimidation and retaliation and/or report potential fraud, waste or abuse to appropriate government officials..

n) If an Employee and Contracted Staff believes in good faith that he/she has been retaliated against for any of the reasons above, the Employee and Contracted Staff should immediately report the retaliation to the Compliance Officer or the Compliance Hotline. The report should include a thorough account of the incident(s) and should include the names, dates, specific events, the names of any witnesses, and the location or name of any document that supports the alleged retaliation.

o) Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Officer or the Compliance Hotline.

B. Management (includes executives, directors, and managers):

1. Any member of management who receives a report of a violation or suspected violation will immediately notify the Compliance Officer.

2. Management must take appropriate measures to ensure that all levels of management support this policy and encourage the reporting of problems and concerns. At a minimum, the following actions should be taken and become an ongoing aspect of the management process:

a) Meet with department staff and discuss the main points within this policy; and

b) Provide all department staff with a copy of this policy.

C. Compliance Officer:

1. The Compliance Officer will ensure that all reports of violations or suspected violations are recorded.

2. The Compliance Officer will determine the scope of the reported issue and make a determination regarding the course of action, including the investigation process and notifications to be made. (Refer to CP008 Investigation of and Resolution of Compliance Issues policy.)
3. The Compliance Officer will be responsible for the investigation and follow-up of any reported retaliation against an employee for reporting a compliance concern or participating in the investigation of a compliance concern.
4. The Compliance Officer will report the results of an investigation into suspected retaliation to the governing entity deemed appropriate, such as the Compliance Committee or the Board of Directors.

III. **Associated Policies**

- CP008 Investigation of and Resolution of Compliance Issues

IV. **References**

- New York State Human Rights Law (NYSHRL), the New York General Obligations Law and the Civil Practice Law.

Title:	Investigation and Resolution of Compliance Issues			**Policy #:**	CP008
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) to respond to reports or reasonable indications of suspected non-compliance by commencing a prompt and thorough investigation of the allegations to determine whether a violation has occurred.

II. Procedures

A. Initial Inquiry

1. Upon report or notice of alleged non-compliance, the Compliance Officer will conduct an initial inquiry into the alleged situation.
2. The purpose of the initial inquiry is to determine whether there is sufficient evidence of possible non-compliance to warrant further investigation.
3. The initial inquiry may include documentation review, interviews, audit, or other investigative techniques.
4. The Compliance Officer should:
   a) Conduct a fair and impartial review of relevant facts;
   b) Restrict the inquiry to those necessary to resolve the issues; and

c) Conduct the inquiry with as little visibility as possible while gathering pertinent facts relating to the issue.

5. If deemed appropriate, the Compliance Officer will recommend the cessation of internal activities that may be the cause of, or contribute to, the alleged non-compliance.

B. Legal Counsel Involvement

1. If, during the initial inquiry, the Compliance Officer determines that there is sufficient evidence of possible noncompliance with any criminal, civil, or administrative law to warrant further investigation, the issue will be reviewed with legal counsel.

2. A memorandum to this effect should be directed to legal counsel, as directed by legal counsel, with a copy to the Executive Director.

a) The memorandum should state whether legal counsel or the Compliance Officer will be leading the investigation.

3. The Compliance Officer, in consultation with legal counsel, the Executive Director and Human Resources, if necessary, will evaluate the violation to determine if a voluntary self-disclosure of the violation is appropriate in accordance with the CP016 Self-Disclosure policy.

a) Self-disclosure (after discussion with counsel and the Executive Director) shall be made in accordance with CP016 Self-Disclosure and may include restitution of monies paid by the applicable federal or state agency, payer, or other entity.

4. The Compliance Officer will consider whether the investigation should be conducted under attorney/client privilege.

5. All documents produced during the investigation by legal counsel to be possibly protected from disclosure should include the notation: "Privileged and Confidential Document; Subject to Attorney-Client Privileges; Attorney Directed Work Product."

C. Investigation

1. The Compliance Officer will conduct or oversee all internal investigations involving compliance-related issues and shall have the authority to engage outside legal counsel or other consultants, if he/she deems it necessary.

2. For investigations that do not involve legal counsel, the Compliance Officer will determine what personnel possess the requisite skills to examine the particular issue(s) and will assemble a team of investigators, as needed.

3. The Compliance Officer shall work with the investigation team to develop a strategy for reviewing and examining the facts surrounding the possible violation.

a) The Compliance Officer will consider the need for an audit of billing practices and determine the scope of interviews.

4. The Compliance Officer will maintain all notes of the interviews and review of documents as part of the investigation file.
5. The Compliance Officer should ensure that the following activities are accomplished:
    a) Full debrief of the complainant;
    b) Notification of appropriate internal parties;
    c) Identification of the cause of the problem, the desired outcome, affected parties, applicable guidelines, and possible regulatory or financial impact;
    d) Provision of a complete list of findings and recommendations;
    e) Determination of the necessary corrective action measures, (e.g., policy changes operational changes, system changes, personnel changes, training/education); and
    f) Documentation of the investigation.

D. Investigation Conclusion

1. Upon receipt of the results of the investigation, depending upon the scope and severity of the identified violations, the Compliance Officer may consult with outside legal counsel, the Executive Director, and/or Human Resources if necessary to determine:
    a) The results of the investigation and the adequacy of recommendations for corrective actions;
    b) The completeness, objectivity, and adequacy of recommendations for corrective actions; and/or
    c) Further actions to be taken as necessary and appropriate.
2. The Compliance Officer will organize the investigation information in a manner that enables FLIPA to determine if an infraction did, in fact, occur. Documentation maintained will include a description of the investigative process; copies of interview notes; other documents essential for demonstrating that the provider completed a thorough investigation of the issue.
3. The Compliance Officer will track the investigation, responsible parties, and due dates. He/she will also log the resolution of the investigation as closed or fully resolved.
4. The Compliance Officer will be responsible for reporting the results of all investigations to the Executive Director and the Board.
5. The Compliance Officer or the applicable director will inform the reporter, if known, of the conclusion of the investigation and the outcome, if appropriate.

III. **Associated Policies**

- CP016 Self-Disclosure

Title:	Internal Auditing and Monitoring			**Policy #:**	CP009
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. **Policy**

The Finger Lakes Independent Provider Association (FLIPA) will conduct ongoing auditing and monitoring of identified risk areas related to compliance including but not limited to the compliance program.

The management team (which includes executives, directors, managers, and supervisors) will ensure that ongoing auditing and monitoring is properly conducted, documented, and reported.

The Compliance Officer will be responsible for oversight of FLIPA internal auditing system and is authorized to delegate auditing duties to other FLIPA personnel, accountants, consultants, and attorneys, as necessary and appropriate.

II. **Procedures**

A. Audit Work Plan

1. On an annual basis, the Compliance Officer, in conjunction with the Executive Director, the management team and the Compliance Committee, will determine the scope and format of routine audits of FLIPA's operations. The Compliance Officer will include all scheduled audits on a work plan that is shared with the Compliance Committee and the Board of Directors.

B. Audit Performance

1. The Compliance Officer will:

a) Recommend and facilitate auditing and monitoring of the identified risk areas related to compliance with laws and regulations as well as FLIPA policies, procedures, and standards of conduct. (Risk areas will include: billings; payments; ordered services; medical necessity; quality of care; governance; mandatory reporting; credentialing; contractor, subcontractor, agent, or independent contractor oversight; documentation; fiscal management, including contractual relationships; privacy/security and Human Resources practices relating to the Corporate Compliance Program, and other risk areas that are or should reasonably be identified by the FLIPA through organizational experience.);

b) Determine the sample size and sample criteria prior to each audit;

c) Facilitate all audits of financial processes or systems with the Director of Finance. The audits will serve to ensure that internal controls are in place so that Generally Accepted Accounting Principles (GAAP) are followed; and federal, state, and local laws, regulations, and requirements are met; and

d) Facilitate all audits of operational and programmatic issues with FLIPA's management team as necessary.

2. The audits will serve to evaluate, at minimum, the following:

- Compliance with laws, regulations, and related policies and procedures and operations;
- Fraud and abuse issues;
- Third party billing practices;
- Documentation practices;
- Employment practices;
- Conflicts of Interest;
- Contract review;
- Employee, independent contractor, and board compliance training and education; and
- Compliance Plan and related policies.

3. The audits and reviews may examine FLIPA's compliance with specific rules and policies through:
    - On-site visits;
    - Personnel interviews;
    - General questionnaires (submitted to employees and contractors); and
    - Documentation reviews.
4. All review tools used will be standardized throughout FLIPA and approved by the Compliance Officer.
5. The Compliance Officer will conduct and/or oversee compliance reviews with assistance from management staff and/or quality assurance/internal audit staff with the requisite skills to carry out the audit.
    a) Whenever feasible, the Compliance Officer will seek to have audits conducted by FLIPA employees who are not involved in the delivery of services subject to the audit.
6. Each FLIPA program will conduct a review of its compliance with applicable regulations and quality measures on an annual basis. The management team shall be responsible to identify needs for internal auditing of specific issues under their oversight.

C. Regulatory Agency Correspondence

1. Any correspondence from any regulatory agency charged with administering a federally or state funded program received by any department of FLIPA will be copied and promptly forwarded to the Compliance Officer for review and subsequent discussion by the Compliance Committee.

D. Audit Report

1. A written report of internal audit findings will be forwarded to the Compliance Officer within seven (7) days from the completion of the internal audit.

E. Corrective Action

1. If deficiencies are noted and a corrective action required, then within thirty (30) days of receipt of the written report of findings, the affected Director(s) will submit a written Plan of Corrective Action including remediation activities to the Compliance Officer for review.

2. The affected Director is responsible to ensure that corrective measures are implemented and monitored for effectiveness within their respective area(s).

F. Post-Audit Review

1. The Compliance Officer will ensure that a post-audit review, if warranted, is scheduled to occur within six (6) months of the completion dates specified in the Plan of Corrective Action.

G. Monitoring Compliance Plan Effectiveness

1. On an annual basis, the Compliance Officer will monitor the effectiveness of the Compliance Plan and will update compliance policies and procedures, as necessary, to comply with regulatory changes or industry trends.

    a) Results of this review will be reported to the Compliance Committee and Board of Directors.

H. Reporting

1. The Compliance Officer will report:

    a) The general status of compliance reviews, the outcome of compliance auditing and monitoring, and the corrective actions taken to the Compliance Committee.

        (1) The reporting will occur at the first regularly scheduled Compliance meeting after the conclusion of the audit.

    b) The results of auditing and monitoring activities and corrective actions at least annually to the Board of Directors.

        (1) The report will also include an assessment of any compliance risks to FLIPA.

I. Benchmarking Audit Results

1. On a year-to-year basis, the Compliance Officer will benchmark audit results and compare results of similar audits to determine whether improvement is occurring.

J. Documentation

1. The results of all internal auditing and monitoring activities, including records reviewed, audit results, and corrective actions, will be recorded and maintained by the Compliance Officer.

Title:	Response to Governmental Investigations			**Policy #:**	CP010
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) to appropriately respond to and not interfere with any lawful audit, inquiry, or investigation.

II. Procedures

A. Announcement

1. Announcement of an impending visit by any government investigator or auditor should be immediately reported to the Compliance Officer who is responsible to notify the Executive Director and legal counsel.
2. Employees will remain courteous and professional when dealing with investigators or agents.

B. On-site Visit

1. If an individual arrives at any FLIPA facility and identifies himself or herself as a government auditor, investigator, or other representative, treat him or her with respect and courtesy. Request identification (do not attempt to photocopy credentials, as this is a violation of Federal law) and the reason for the visit.

2. Ask the individual to wait in an unused office or a location where business is not conducted.
3. Immediately contact the Compliance Officer who will contact the Executive Director and legal counsel.
4. Await direction from legal counsel. You are not required to submit to questioning or an interview. Do not provide documents or other information. The Executive Director will identify one employee to be responsible for responding to the agent's questions.
5. Other than providing information to direct the agents to information requested, you are not required to submit any form of questioning or interviewing.
6. Employees should report any off-site visits by government agents, investigators, or auditors to the Compliance Officer. The Compliance Officer will notify the Executive Director and legal counsel.

C. Search Warrant or Subpoena

1. Procedures for handling the receipt of a search warrant or subpoena are covered by separate policies. Please refer to specific policies CP011 and CP012.

III. **Associated Policies**

- CP011 Response to Search Warrants
- CP012 Response to Subpoenas

Title:	Response to Search Warrants			**Policy #:**	CP011
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) to advise all employees how to appropriately respond to an official search warrant.

II. Procedures

A. Delivery

1. Employees will not interfere with the lawful execution of a search warrant.
2. Employees will remain courteous and professional when dealing with investigators or agents.
3. Obtain and record the name of the lead agent and the agency they represent. Do not attempt to photocopy the credentials of an agent - it is a violation of Federal law.
4. Request to view and photocopy the search warrant document.
5. Immediately contact the Compliance Officer and provide him/her with details of the search warrant. The Compliance Officer will contact the Executive Director and legal counsel and provide details of the search warrant. The Compliance Officer will identify one employee to be responsible for responding to the agent's questions.
6. Request an "inventory list" of the documents and items seized by the agents. Ensure that it is detailed enough to properly identify the documents and items taken by the agents. Maintain a separate record of the areas searched, listing the documents/items seized from the area.

7. Other than providing information to direct the agents to information requested, you are not required to submit to any form of questioning or interviewing.
8. Always remain present while the agents are conducting the search.

B. Compliance Officer Responsibilities

1. The Compliance Officer will carefully examine the search warrant (with legal counsel, if possible) to:
   a) Determine the specific areas or locations it covers;
   b) Ensure that it is being executed during the hours indicated on the document (most warrants should limit the hours they can be executed, e.g., "daylight hours");
   c) Ensure that it has not expired (all warrants should have an expiration date); and
   d) Ensure that it is signed by a Judge (all warrants should be signed by a Judge).
   e) Politely object if there is any overt flaw in the search warrant (as described above) or if the agents are searching anything deemed to be outside the scope of the warrant.
   f) Do not interfere should agents proceed and search. Note the fact for legal counsel to support a future protest.

Title:	Response to Subpoenas			**Policy #:**	CP012
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

This policy refers only to subpoenas related to business matters of Finger Lakes Independent Provider Association (FLIPA).

A subpoena is an official demand for testimony or the disclosure of documents or other information. They may originate from law enforcement or administrative agencies. Every subpoena requires a careful legal review prior to response.

FLIPA is committed to full compliance with any lawful subpoena. Employees will remain courteous and professional when dealing with investigators or agents delivering a subpoena. No one is to impede in any way efforts to deliver a subpoena.

II. Procedures

A. Receipt of a Subpoena

1. The Compliance Officer shall be immediately notified of the receipt or delivery of a subpoena related to FLIPA business (regardless of delivery method) including any information obtained (e.g., the name, title, and telephone number of the serving agency investigator, information provided by the agency investigator).
2. If the subpoena is received, either via the mail or email, it must be delivered or forwarded along with a call immediately placed to the Compliance Officer.

3. If being delivered in person, and the appropriate or requested individual is onsite, call them to reception so the agency investigator may deliver the subpoena to them. You are not required to volunteer information to an agency investigator or submit to any form of questioning or interviewing.
4. The requested individual is not required to volunteer any information or answer any questions from the investigator upon or after delivery of the subpoena.

B. Response to a Subpoena

1. The Compliance Officer will review the subpoena for validity and scope. The majority of subpoena's are not valid unless delivered in person.
2. The Compliance Officer will promptly notify the Executive Director and legal counsel of receipt.
3. The Compliance Officer, in conjunction with legal counsel will determine next steps and inform the Executive Director, and the individual originally involved and/or Board of Directors as appropriate.

Title:	Policy and Procedure Development and Renewal			**Policy #:**	CP013
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of the Finger Lakes Independent Provider Association (FLIPA) to have clearly written and understandable policies and procedures. These policies and procedures will be maintained centrally and be accessible to all interested persons. This policy applies to directors and above who are responsible for creating, distributing, reviewing, and revising as necessary but no less than every 3 years.

II. Procedures

A. Sections

1. Policy Number: Each policy number begins with a two (2) or three (3) letter department identifier (i.e. CP = Compliance, FN = Finance, HR = Human Resources, IT = Information Technology as identified as necessary) followed by sequential three-digit numbers (e.g., 001, 002, etc.).
2. Policy Title: Captures the content of the policy and will not include the word "policy."
3. Policy Statement: provides a rationale for the policy including the underlying philosophy of the policy and what the policy hopes to accomplish. In addition, or alternatively, this section may contain overarching rules that FLIPA will follow concerning the subject matter. When applicable, this section should include reference to the guiding regulation. Policy statements range from one to two sentences to a paragraph in length, depending upon the subject matter.

4. Procedure: Includes the steps necessary to comply with the policy, with sufficient detail that end users will readily understand how to comply with the policy mandates. Procedures must be consistent with the policy section. Forms associated with the procedure should be included at the end of the document as "Attachments".
5. Definitions: May be included if there are any uncommon words or words with meanings. They should be defined and listed in alphabetical order.
6. References: May be included to document regulatory or industry references used.
7. Associated Policies: May be included if the document references other FLIPA policies or procedures. The referenced policy number and title should be listed.
8. Attachments: Should be included if there are applicable forms or appended information referenced within the policy that should be attached to the policy.

B. Style

1. All policies are to be drafted using the applicable FLIPA template in the Policy Hub.
2. Font is MS Word, using Barlow 11 pt. font and 1" margins.
3. Main section titles (e.g., "Policy" and "Procedures") are to be bold, underlined, and in Barlow 11 pt. font.
4. Alignment – Full document must be justified.
5. Bottom left footer – page number beginning on page 2 and the policy name.
6. Policies are to be clear and concise and written in the third person.
7. Select words carefully. Words such as "should" and "may" imply choice.
8. Do not use information that may quickly become outdated such as employee names or web addresses.
9. When using acronyms, spell out the words the first time, then indicate the acronym in parenthesis (e.g., State Board of Education (SBOE)).
10. Write in terms that are easily understood by the general population.

C. Review, Approval, and Publication

1. At the origination of or during the annual review of a policy, the owner reviews the policy with their team if appropriate.
2. The Policy & Procedure Committee reviews each policy.
    a) If there are outstanding questions or it is not approved, the policy owner or his/her designee makes the revisions for review at the next meeting.
3. Teams and the applicable Committee. The policy owner will bring the draft/revised policy to the applicable Committee at his/her discretion.

a) Compliance Policy = Compliance Committee

b) Information Technology (IT), Privacy, Security Policy = IT Committee

c) Finance, Human Resources Policy = Finance & Contracting Committee

d) Communication, Facilities Policy = Executive Director

4. The P&P Chair or designee reviews with the Executive Director for approval.
5. Once "approved" by the Executive Director, the P&P Chair or Executive Director sends the policies to the full Board of Directors via email for review and approval.
6. Once approved by the Board, the P&P chair or designee adds the effective date, accepts all final changes and ensures proper format.
7. The P&P Committee Chair designee also replaces the old with the new in the "Compliance Library", which makes the policy visible to all FLIPA Staff.

D. Roll-Out and Training

1. The policy owner determines the best avenue for roll-out and training based on:
   a) Audience (all or specific limited); and
   b) Whether it is a major or minor change.
2. Roll-out and training can be done via email for minor changes or through specific training for major changes.
3. Roll-out and training must be completed within thirty (30) days of finalized policy.

Title:	Record Creation, Retention and Document Destruction			**Policy #:**	CP014
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) to ensure that records and documents are adequately protected and maintained and to ensure that records that are no longer needed or are of no value are discarded at the proper time. The procedures outlined below are for the purpose of aiding FLIPA employees to understand their obligation to not knowingly destroy a document with the intent to obstruct or influence an investigation or proper administration of any matter.

II. Procedures

A. Purpose

1. To demonstrate that FLIPA can substantiate the payments received and provided to partners.
2. Employees, contracted staff, vendors and partners are expected to maintain complete and accurate records as required that provide support for the receipt of distributions by FLIPA.

B. Alteration of Records

1. All records required either by Federal or State law or by the Compliance Plan will be appropriately created and maintained. Records should never be altered without permission of the Compliance Officer.
2. In the case of a necessary alteration, the alteration should be signed and dated by the staff member altering the document.
3. Signatures should always be accompanied by the date that the signature was made. Dates in all cases should include the month, date and year.
4. Documents must never be backdated or predated.
5. Signature stamps shall not be used. Under no circumstances shall any person sign the name of another individual.

C. Record Destruction

1. All documentation to be destroyed will be shredded or disposed of by an outside vendor who specializes in document destruction services. Onsite Documentation Destruction by an outside vendor will be witnessed by designated staff.
2. Destruction of records after the appropriate retention period will be carried out by a staff member assigned this task by a Senior Director or the Executive Director.
3. The destruction of any FLIPA documentation or records after a request has been made to review these records or an investigation or review has been commenced by any governing body is prohibited.

D. Record Retention

1. Records will be retained according to the following schedule. For items not listed below consult Records Retention and Disposition Schedule CO-2 of the New York State Archives Government Record Services, Section 185.13, 8 NYCRR.

TYPE OF RECORD	**RETENTION PERIOD**
ACCOUNTING	
Accounts receivable subsidiary ledgers	7 years
Accounts payable subsidiary ledgers	7 years
Auditors' reports/schedules	permanently
Bank deposit slips	3 years
Bank statements, reconciliations, check registers, investment statements	7 years
Budgets	2 years
Cancelled checks, generally	7 years
Cancelled checks, important payments	permanently
Cash disbursements journal	permanently

Cash receipts journal ..... permanently
Contracts, government and general (after expiration/termination) ..... 15 years
Depreciation records ..... permanently
Employee expense reports ..... 7 years
Annual financial statements ..... permanently
Interim/internal financial statements ..... 3 years
General journal/ledger and end-of-year trial balances ..... permanently
Inventory lists ..... 7 years
Invoices to customers ..... 5 years
Invoices from vendors ..... 5 years
Internal audit reports ..... permanently
Petty cash vouchers ..... 3 years

CORPORATE RECORDS

Annual reports ..... permanently
Articles of incorporation ..... permanently
Constitution and bylaws ..... permanently
Board and board committee minutes ..... permanently
Meeting files (agendas, background materials, other notes) ..... 1 year
Contracts and leases (expired) ..... permanently
Contracts and leases (active) ..... permanently
Deeds, mortgages and bills of sale ..... permanently
Legal correspondence (important) ..... permanently
Property appraisals ..... permanently
Property records ..... permanently
Tax-exemption documents (IRS 1023) ..... permanently
Policies, procedures and standards ..... 6 years after superseded
Grants and related documents ..... 6 years after renewal, grant close or denial
Annual, special or final report, summary, review
or evaluation containing substantial evidence of
government policy, procedure, plan and direction ..... permanently

Reports where critical information is contained
in other reports or contain routine legal, fiscal, and administrative information ..... 6 years
Surveys or inspection records from state or federal overseers ..... permanently

INSURANCE

Accident reports and claims (settled cases) ..... 7 years
Expired insurance policies ..... 7 years
OSHA records of employee exposure to toxins ..... 30 years
OSHA records of employee handling of toxins ..... 40 years

PERSONNEL

Employee files (after termination) ..... 7 years
Employment applications ..... 3 years
Job advertisements and orders to employment agencies ..... 1 year
Payroll records, summaries and tax returns ..... 7 years
Pension/profit sharing retirement plan tax information, returns,
and correspondence ..... permanently
Time cards and daily reports ..... 7 years
NYS Right to Know Law – employers report of injury (C-2) ..... 18 years
NYS Workers Comp Board postal & meter records ..... 1 year
Affirmative Action Documents, Executive Order - 1246 ..... 3 years

TAXES

Income tax returns and cancelled checks ..... permanently
Payroll tax returns ..... 7 years
Property tax returns ..... permanently
Sales and use tax returns ..... 7 years

PROGRAM RELATED

Anything related to False Claims Act ..... 10 years
Anything related to collection of DSRIP funds ..... 10 years
Case records – adult cases ..... 7 years

Case records – minors ..... 7 years after the client's 21st birthday

Referrals and advice case not opened ..... 6 months

Screening and assessment records and referrals or persons evaluated, but not treated ... 3 years

Title:	External Audits			**Policy #:**	CP015
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

It is the policy of Finger Lakes Independent Provider Association (FLIPA) to fully cooperate with any lawful audit by a third party that is either initiated by a regulatory agency or an agency retained by FLIPA.

II. Procedures

A. Notification

1. To ensure that all external audit activity is appropriately coordinated, the Compliance Officer must be notified immediately upon receipt of an audit request. Upon notification, the Compliance Officer and Senior Director of area to be audited determine who will participate in the external audit activity.

B. Coordination

1. Coordination of the external audit activity includes:
   a) Notifying all leadership;

b) Identifying and notifying appropriate staff, including applicable Management;
c) Arranging for a dedicated conference room for the auditors to work;
d) Notifying IT for any system access requirements;
e) Notifying Security for any physical access needs, and
f) Ensuring their access to and use of the secure audit filing cabinet.

C. Entrance Conference

1. The Compliance Officer including applicable Management and staff involved in the audit will participate in the entrance conference.
2. The entrance conference is an opportunity to discuss the scope of the audit, timing, available resources, and other concerns.

D. Exit Conference

1. The Compliance Officer including applicable Management and staff involved in the audit will participate in the exit conference.
2. The exit conference follows the fieldwork completion by the auditor(s) and provides an opportunity for the auditors to review their draft findings/report.

E. Response to Draft Report

1. The Executive Director or designee in conjunction with the Compliance Officer, applicable Management and Controller (if applicable) approves all responses to draft and final audit reports prior to submission to the auditing agency.

F. Final Report

1. The Compliance Officer or Senior Director (when applicable) coordinates the distribution of the final audit report to necessary committees including the FLIPA Board of Directors and follows-up to ensure timely completion of remediation activities.

Title:	Resolution of Compliance Issues			**Policy #:**	CP016
Type:	Compliance	**Effective Date:**	9/3/21	**Board Approval Date:**	9/3/21
Revised Dates:					

Contents

I. Policy

The Finger Lakes Independent Provider Association (FLIPA)is committed to correcting non-compliant behavior and taking necessary corrective actions. It is committed to the ongoing good faith disclosure of potential fraud, waste and abuse and cooperation with the United States Department of Health and Human Services Office of Inspector General (OIG) and the New York State Office of the Medicaid Inspector General, as applicable, to maintain the integrity of federal health care programs. In deciding to follow the OIG's Self-Disclosure Protocol or OMIG's (SDP), FLIPA will demonstrate its commitment to investigate such instances, assess the potential losses suffered by the Federal health care programs, and make full disclosure to the appropriate authorities. FLIPA will also ensure additional remedial measures in the event improvements to best practices are uncovered.

II. **Procedures**

A. Upon discovering non-compliance after an investigation, the following will occur.

1. Corrective Action. The Compliance Officer, in consultation with the Executive Director and/or Program directors, is generally responsible for drafting, reviewing and approving corrective action plans. However, if the subject of the corrective action plan is the Executive Director, the Compliance Officer shall seek the review and approval of the corrective action plan from the Board of Directors.

a) Corrective action may include, but not be limited to, any of the following steps:

i. Modifying the Organization's existing policies, procedures or business practices;

ii. Providing additional training or other guidance to employees, contractors, or Board members;

iii. Seeking interpretive guidance of applicable laws and regulations from government agencies and/or legal counsel;

iv. Disciplining employees, terminating contractors and sanctioning Board members as described more fully in FLIPA's disciplinary policies.

v. Notifying government agencies of improper conduct by employees, contractors, board members, or others; and/or

vi. Reporting and returning overpayments or other funds to which the Organization is not entitled to the appropriate government agency or payor, including through the OMIG's voluntary self-disclosure program if applicable.

2. Non-Compliant Billing Issues. In the event the investigation reveals a non-compliant billing issue, such as the use of an improper code, the following action will be taken:

a) If an overpayment has been made by Medicaid, Medicare, and/or any other state or federal health care program(s) because of an error, mistake, or otherwise inappropriate claims submission, (i) the defective practice or procedure will be corrected as quickly as possible; (ii) overpayments will be identified and quantified, and repaid no later than sixty (60) days of from the date for quantification; and (iii) a program of education and/or corrective action plan will be undertaken with appropriate individuals and entities to prevent similar problems in the future.

III. **Associated Policies**

- CP008 Investigation and Resolution of Compliance Issues

IV. **References**

- OIG's Provider Self-Disclosure Protocol