Glens Falls Hospital
An affiliate of ALBANY MED

Title: Corporate Compliance Program at Glens Falls Hospital

Area: Compliance

Effective Date: July 1, 2021

Scope:

Trust in Principled Performance (TIPP) is the compliance program adopted by the Albany Med Health System (AMHS).

This policy applies to all employees, physicians, and business partners of Glens Falls Hospital.

Purpose:
Glens Falls Hospital (the "Hospital" or "GFH") believes that conscientious dedication to the highest ethical standards is essential to its mission. This dedication is essential because the Hospital is charged with serving the community, and because a significant portion of the Hospital's services are reimbursed through governmental programs which require that the people's business be conducted with complete integrity. The Hospital is committed to complying with all applicable Federal and State standards.

For these reasons, AMHS and the Hospital has designated a System Compliance Officer and an Entity Compliance Officer to have day-to-day responsibility for its compliance efforts. The Hospital also has established a Corporate Compliance Council (the "Council"), to assist the Compliance Officer.

Guidelines:

I. OBJECTIVES OF THE CORPORATE COMPLIANCE PROGRAM

Constant vigilance is necessary to avoid impropriety or the appearance of impropriety. Consequently, AMHS and the Hospital has developed a Compliance Program (the "Program") to set standards for conduct, and monitor conduct, in various areas of the Hospital's activities. Although the implementation and enforcement will be the chief responsibility of the System Compliance Officer~~,~~ the responsibility for compliance rests with each department, or service, medical professional, employee, and business partner of the Hospital. Ultimately, compliance is the responsibility of every Hospital employee, business partner, and every independent professional who enjoys Hospital staff privileges. All Employees, medical staff and business partners have a responsibility to conduct business in a manner that supports integrity in operations and a responsibility to report compliance issues to the Compliance Officer or their direct supervisor.

II. GENERAL OPERATION OF THE PROGRAM

A. Objectives of the Program

The objectives of the program are:

1. to assist the Hospital in preventing inappropriate transactions.

2. to assist the Hospital in preventing irregularities in payment, reimbursement, and other transactions.

3. to assist the Hospital's management, medical staff and employees through education in identifying areas of possible concern that may adversely affect the Hospital's good reputation, its participation in public programs, or its status as the holder of public licenses, certifications and exemptions;

4. to provide additional oversight of the Hospital's compliance with laws, regulations and special conditions imposed upon it by a licensing or regulatory authority.

B. Duties of the Corporate Compliance Officer

The responsibility for operation of the Program and for preparation of reports relating to it rests with the AMHS Compliance Officer. The success of the Program depends on the active participation of the Hospital's senior executives, Board of Governors, financial and claims staff, and the leadership of the departments, Hospital vendors, business partners and the professional medical staff. Through the dissemination of the Compliance Policies (described below) and appropriate training, all such persons shall be advised regarding their responsibilities for the Program, and the circumstances in which they should notify the Entity Compliance Officer on a timely basis of matters subject to review under the Program.

The Entity Compliance Officer will be provided with the resources necessary to fulfill his/her responsibility for operation of the Program. The Corporate Compliance Officer may inquire into any matters arising or appearing to arise within the purview of the Program including, but not limited to, matters involving unethical conduct, irregular billing, claims or payments and regulatory compliance. The Hospital's other personnel, including but not limited to, accountants and legal counsel shall be available to assist the Corporate Compliance Officer in his/her duties.

The Compliance Officer is to be informed of all instances where fraudulent activity is suspected, identified, or reported. Such instances will include direct referrals of potentially fraudulent activities to the Compliance Hotline, reports of potential fraud made directly to management and breaches of Information Technology security. The Compliance Officer will initiate an investigation and coordinate such investigation as appropriate.

Recommendations following such investigations will be made to senior management and as necessary to the System Compliance Officer, and Board of Governors.

The Compliance Officer will be provided with resources necessary to fulfill this responsibility, including but not limited to, continued education in compliance, fraud investigation and internal audit. Hospital personnel shall be made available to assist in such investigations as reasonable and necessary.

The Entity Compliance Officer is responsible to and will report to the Hospital Chief Executive Officer and the System Compliance Officer.

C. The Compliance Council

Composition. The Committee shall consist of the Hospital's, Director of Nursing, Director of Risk Management, Director of Human Resources, Director of Patient Financial Services, Director of Corporate Compliance, , Director of Materials Management, Director of Pharmacy, Director of Information Technology, Director of Health Information Services, Director of Surgical Services, Director of Revenue Cycle, Director of Physician Practices and other positions and individuals as deemed necessary.

Duties. The Council will review the audit plan and offer suggestions. Also, when requested by the Compliance Officer, the committee is empowered to investigate, evaluate, and make recommendations to Administration of misconduct by Hospital employees, agents, medical staff, or business partners.

Meetings. The Committee shall meet periodically to review the progress of the compliance plan and reassess risks. The committee will also review any substantial inquiries conducted or supervised by the Compliance Officer. The Corporate Compliance Officer or Hospital CEO may call special meetings of the Council as needed.

Minutes. Written agendas for all meetings of the Committee shall be prepared and maintained by the Compliance Officer along with a record of all recommendations by the Council.

III. POLICY MANUAL

Because of the importance of understanding and abiding by all the Hospital's standards and procedures, the Compliance Officer shall make available to all employees, medical staff and business partners the System's and Hospital's compliance policies. These will be maintained on the Hospital's intranet filed under, Policy Manager. Many relevant compliance policies are available on the hospital's external website. Also, business partners may request written copies of such polices through the Corporate Compliance Officer.

IV. PROCESS, REPORTS AND RECORDKEEPING

It is the employee's, business partner's or provider's responsibility to report any real or suspected compliance concern. A report MUST be made to the individual's supervisor or point of contact. The supervisor or point of contact should then contact the compliance team.

The Hospital has established a confidential reporting system through which anyone may report either in person or in writing to the Compliance Officer potential problems

without fear of retribution. Employees and other agents may write to the "Compliance Officer, Glens Falls Hospital, 100 Park Street, Glens Falls, New York 12801" or they may call the **Compliance and Fraud Hotline** at 1-800-975-9427. In conducting investigations, the Compliance Officer, Internal Audit staff and the Compliance Council shall respect the confidentiality of privileged records and information and shall comply with applicable confidentiality laws and ethical standards.

V. RESPONSE

1. All files of inquiries will be maintained by the Compliance Officer on a confidential basis. They shall not be disclosed except to:

   (a) Members of the Compliance Council

   (b) Members of management or management representatives having a need to know.

   (c) As may be required by law or court order from authorized jurisdictions.

   Reports of compliance concerns will be investigated by the Compliance Officer or designee. The compliance team may consult with others, including but not limited to human resource associates or legal counsel as needed. Significant issues will be discussed with the CEO, System Compliance Officer and/or Board of Governors.

   AMHS, including GFH, uses a centralized database to record and report compliance issues, events, and inquiries. All activities of substance are recorded in this database. This data is compiled periodically and is reported to AMHS Board and GFH Board of Governors.

2. For those issues noted during audits or self-evaluations, the details would be discussed with the AMHS Compliance Officer, GFH CEO and/or legal counsel as needed. A mutually agreed upon plan would be devised to address the issue.

3. If there is an overpayment found which is due to a governmental payer, it would be investigated promptly in conjunction with the Senior Director of Revenue Cycle. If a repayment is needed, it would be processed on a check request form submitted to the Accounts Payable team and authorized by the Senior Director of Revenue Cycle or the Chief Financial Officer.

4. With all issues raised internally or externally and those noted through audit or self-evaluation, the compliance team or designee will review the following to reduce the potential for recurrence.
   (a) Policies
   (b) Procedures
   (c) Training

VI. AUTHORITY

The compliance and internal audit function, with strict accountability for confidentiality and safeguarding records and information, is authorized full, free, and unrestricted access to all the Hospital's records, physical properties, and personnel pertinent to carrying out any engagement. All employees are requested to assist the compliance and internal audit team in fulfilling its roles and responsibilities. The compliance and

internal audit function will also have free and unrestricted access to the Board of Governors.

VII. ACTS OF WRONGDOING

The Compliance Officer shall report to the Compliance Council demonstrated instances of material violations of the compliance policies or acts of wrongdoing by any employee, member of the medical staff or business partner of the Hospital. The Compliance Officer may raise other matters with the Compliance Council, within his or her discretion.

VIII. COMPLIANCE REVIEWS AND PLANS

The Compliance Officer shall periodically review compliance with regulatory requirements and shall report to the System Compliance Officer any findings regarding such matters. The System Compliance Officer and Entity Compliance Officer shall review relationships between the Hospital and its Board members, employees, agents, or independent professional staff.

Such reviews will be planned annually and reported to the System Compliance Officer and referred to in the Corporate Compliance Plan. This plan will be developed with support from Committee members, legal counsel, senior leaders, and department directors. A periodic component of such plan is to include exclusion testing of employees, physicians, business associates and vendors with the Federal and State exclusion databases.

The Compliance Plan will be developed annually and approved by the AMHS Board Audit & Compliance Committee. The Plan will be developed to comply with the elements required of compliance programs as mandated by the Department of Health and Human Services (HHS) Office of the Inspector General and the New York State of Medicaid Inspector General.

IX. DISCIPLINE

Discipline will be imposed for failure to comply with GFH's Corporate Compliance Program or its Code of Conduct or failure to report a known failure to comply. Sanctions will also be imposed for encouraging, directing, facilitating, or permitting non-compliant behavior. Such discipline can include immediate termination of the relationship with Glens Falls Hospital.

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Policy Tracking Form:

Name of Policy: **Corporate Compliance Program at Glens Falls Hospital**

Replaces Policy:

Contact Person Name: Colleen Susko
Title: Chief Risk and Compliance Officer

Effective Date: July 1, 2021

References:

Origination Date: December 1, 2016

Revision Dates: 7/21

Reviewed Dates: 12/2018

Signature(s):
Dianne Shugrue
Title: President and CEO