

LIBERTY HOSPITAL
Compliance Plan

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LIBERTY HOSPITAL Compliance Plan

I. Introduction

The Compliance Plan (“Plan”) is a fundamental policy of the New Liberty Hospital District of Clay County, Missouri (“Hospital”) requiring that business and other practices be conducted in compliance with ethical business practices and the applicable federal and state laws governing health care programs.

A health care program is defined as any governmental, commercial, private or other organization that reimburses the Hospital for services provided to its patients.

This Plan applies to employees, Trustees, physicians on the medical staff, allied health professionals, students, volunteers, agents and independent contractors providing direct patient care and ancillary services (hereinafter referred to as “Party” or “Parties”). Each Party is responsible for their own conduct in complying with the Plan’s content.

This Plan is designed to establish a culture within the Hospital that promotes prevention, detection and resolution of instances of conduct that do not conform to applicable federal and state laws governing health care programs and to the Hospital’s business and ethical policies. The Hospital has developed guidelines to comply with the laws, regulations and guidelines for health care programs. While the contents in this Plan are intended to set forth those compliance guidelines that pertain to health care programs, as well as to ethical behavior, the Hospital expects each Party to always strive to obey government laws and regulations.

The Plan or excerpts from it shall be distributed to employees, board members and physicians on the medical staff. In addition, any supplemental data dealing with specific compliance topics may be distributed to the affected Parties in certain areas as deemed appropriate by the Compliance Officer. The term “affected” refers to any Parties that, in the discretion of the Compliance Officer, need to receive special attention on compliance matters. This Plan shall be posted for public access via the Hospital website, www.libertyhospital.org.

This Plan shall be monitored on a regular basis and reviewed no less frequently than annually. An independent firm may be engaged by the Compliance Officer to conduct the annual review to determine if the Plan is meeting its objectives. The Compliance Officer, in consultation with the Compliance Committee, may revise the Plan as necessary. Any revisions to this Plan shall be approved by the Board of Trustees of the New Liberty Hospital District of Clay County, Missouri.

The Board of Trustees of the New Liberty Hospital District of Clay County, Missouri previously approved the development of a Compliance Plan on February 19, 1998. The Board of Trustees subsequently adopted the Plan at its meeting on June 17, 1999.

The Hospital is committed to maintaining a high standard of ethical business conduct. The Hospital shall strive to keep its operations, activities and business affairs in compliance with applicable laws and regulations which govern the principles and criteria contained in this Plan. Therefore, Parties shall comply with the provisions contained in this Plan. Additionally, Parties must comply with other Hospital policies and guidelines, including those contained in the employee manual and other policy and procedural manuals.

II. **Hospital Standards of Conduct**

These Hospital Standards of Conduct establish behavioral expectations and the basic legal principals under which the Parties must operate. These Standards of Conduct are neither exclusive nor complete. See the pertinent sections of the Employee Handbook for more information on this subject. The Parties are responsible for ensuring that their behavior and activity is consistent with these Hospital Standards of Conduct, the Employee Handbook, and applicable laws and regulations. Questions about the existence, interpretation or application of any law, regulation, policy or standard should be directed, without hesitation, to an employee's supervisor, the Compliance Officer, or the Hospital's Administrator. Because laws, regulations and policies are constantly evolving, this Plan will be revised and updated as needed. Revisions will be communicated in a timely manner to Hospital employees through administrative notification, and changes will be posted to the Hospital website.

A. *Fraud and Abuse*

The Hospital requires that the Parties adhere to the standards contained in this Plan, as well as other Hospital policies and guidelines, including those contained in the employee manual and other policy and procedural manuals, while serving in their respective capacities on behalf of the Hospital. Conduct that does not comply with these standards is not authorized by the Hospital and shall not be tolerated. Failure to comply with these standards may constitute a violation of the law and shall be subject to disciplinary or other action. If a question arises as to whether any action complies with said policies or laws, the Party shall present that question either to their supervisor, in the case of an employee, or directly to the Compliance Officer, in the case of an employee or other Party. Conduct that does not comply with the standards as contained in this Plan shall be immediately reported to the Compliance Officer. The Hospital expects the Parties to abide by the following standards:

1. No Party shall make any false statement of any kind in any claim or application for health care benefits.

2. No Party shall retain on behalf of the Hospital any funds from any federal, state or private insurance program that the employee knows have not been properly paid.
3. No Party shall knowingly submit on behalf of the Hospital any claim for health care benefits if he/she has reason to believe the services were not medically necessary.
4. No Party shall pay or offer to pay any source for referrals of individuals to the Hospital for services. No Party shall receive or attempt to receive payments from any source for referrals of individuals to other organizations.
5. No Party shall present a claim on behalf of the Hospital to any governmental agency or other payer that is for an item or service that the Party knows was not provided or that the employee knows was false. No Party shall make any false representations regarding coverage of any patient services.
6. No Party shall engage in any conduct or scheme to cheat or defraud any health care program or governmental agency.
7. No Party shall falsify or conceal any facts concerning the delivery of services or payments of benefits in connection with any health care program.
8. No Party shall either destroy the information or records related to a potential health care offense or obstruct the investigative process.
9. No Party shall use any funds obtained improperly or illegally from any health care program.
10. No Party shall fail to report an incident which shall be considered as a violation of any standard of conduct as contained in this Plan or in any other Hospital policies.
11. No Party shall prevent a person who acts pursuant to their responsibilities under this Plan from making reports for alleged facility mismanagement or fraudulent activities.

B. *Honest Communications*

The Hospital requires the Parties to perform their duties and responsibilities honestly and ethically. The Hospital expects verbal and written communications from the Parties to other persons to be honest and ethical at all times. The Parties shall not

make false or misleading statements to any person or persons regarding the services or products provided by the Hospital.

C. *Misappropriation of Proprietary Information*

Parties are prohibited from misappropriating any confidential or proprietary information. This shall include software, contracts, agreements, documents, records and other sensitive or restrictive information which may not be used in an unauthorized manner.

D. *Confidentiality*

The Hospital's policy is that its operations, activities and business affairs, including those relating to patient matters, shall be kept confidential, subject to necessary compliance with applicable state and federal laws, rules and regulations including, but not limited to, state open records law pertaining to governmental hospitals.

1. **Patient.** The confidentiality of patient information and records is essential. Parties shall maintain the confidentiality of patient information and records and shall not inappropriately release information to other employees, third parties, vendors, or the public which may result in injury to either the patient, the Hospital or to other Parties. An exception shall be made for any proper requests made in accordance with applicable laws and regulations.
2. **Corporate.** Parties with either access to or the ability to obtain confidential information about the business matters of the Hospital shall not discuss such information with anyone except those who have a legitimate need to know the confidential information about the business matters of the Hospital to perform their job functions. An exception shall be made for any proper requests made in accordance with applicable laws and regulations.
3. **Personnel.** Information relating to employees of the Hospital is confidential. Personnel information shall be maintained in accordance with Hospital guidelines and applicable laws governing employment. Personnel having access to such information shall exercise due care in protecting its confidentiality and limit the dissemination of such information to only those individuals in the organization who need the information to perform their job functions. An exception shall be made for any proper requests made in accordance with applicable laws and regulations.

E. *Conflicts of Interests*

Policy: The Hospital recognizes that there is a potential for conflicts of interest. In conducting its business activities, Trustees, management, committee members, employees, contractors and other persons owe a duty of loyalty to the Hospital. Toward the end, the Hospital has established guidelines to avoid conflicts of interest and protect the assets of the Hospital. Persons holding such positions may not use their position to profit personally, or to assist in profiting in any manner at the expense of the organizations.

1. All elected and appointed officials as well as employees of a political subdivision must comply with §105.454 of Missouri Revised Statutes on conflicts of interest as well as any other state law governing official conduct.
2. Any member of the New Liberty Hospital District's Board of Trustees who has a "substantial personal or private interest" in any measure, bill, order or ordinance proposed or pending before the New Liberty Hospital District Board of Trustees must disclose that interest to the secretary or clerk of the New Liberty Hospital District's Board of Trustees. Substantial personal or private interest is defined as ownership by the individual, their spouse, or their dependent children, whether singularly or collectively, directly or indirectly of: (1) 10% or more of any business entity; or (2) an interest having a value of \$10,000 or more; or (3) the receipt of salary, gratuity, or other compensation or remuneration of \$5,000 or more, per year from any individual, partnership, organization, or association within any calendar year.
3. **Procedure** – The management employees of the New Liberty Hospital District are prohibited from the following acts:
 - a. Failure to notify administration of a private interest, direct or indirect, in any vendor doing business with the hospital; or
 - b. Accepting personal gifts or gratuities directly or indirectly from vendors doing business with the hospital, except for non-monetary gifts or gratuities of a nominal value.
4. Management employees are to sign a conflict of interest statement annually (every June) or at the time of employment.
5. In the event that a management employee is aware of a situation whereby he/she or a relative has a private interest, or employment, either direct or indirect, in a vendor or physician doing business with the hospital, he/she must notify the administrator immediately. The administrator shall determine within 30 days of receipt of the notice whether or not the private interest

constitutes a conflict of interest. If a conflict of interest exists, the management employee has 60 days to divest their interest in the vendor or leave the employ of the hospital.

6. Management employees determined to be accepting personal gifts and gratuities (other than non-monetary gifts of nominal value) directly or indirectly from vendors may be subject to disciplinary action by the Hospital.

Disclosure Reports: Each elected official, the Administrator, the Director of Materials Management, the employed general counsel, and all officials or employees authorized to promulgate or vote on rules and regulations with the force of law shall disclose the following information by May 1, if any such transactions occurred during the previous calendar year.

1. For such person, and persons within the first degree of consanguinity or affinity of such person, the date and the identities of the parties to each transaction with a total value in excess of five hundred dollars, if any, that such person had with the New Liberty Hospital District, other than compensation received as an employee or payment of any tax, fee or penalty due to the New Liberty Hospital District, and other than transfers for no consideration to the Hospital.
2. The data and the identities of the parties to each transaction known to the person with a total value in excess of five hundred dollars, if any, that any business entity in which such person had a substantial interest, had with the Hospital, other than payment of any tax, fee or penalty due to the Hospital or transactions involving payment for providing utility service to the Hospital, and other than transfers for no consideration to the Hospital.
3. The Administrator and the Director of Materials Management shall also disclose by May 1, for the previous calendar year, the following information:
 - a. The name and address of each of the employers of such person from whom income of one thousand dollars or more was received during the year covered by the statement.
 - b. The name and address of each sole proprietorship that he owned; the name, address and the general nature of the business conducted of each general partnership and joint venture in which he was a partner or participant; the name and address of each partner or co-participant for each partnership or joint venture unless such names and addresses are filed by the partnership or joint venture with the Secretary of State; the name, address and general nature of the business conducted of each general

partnership and joint venture in which he was a partner or participant; the name and address of each partner or co-participant for each partnership or joint venture unless such names and addresses are filed by the partnership or joint venture with the Secretary of State; the name, address and general nature of the business conducted of any closely held corporation or limited partnership in which the person owned 10% or more of any class of the outstanding stock or limited partnership units; and the name of any publicly traded corporation or limited partnership that is listed on a regulated stock exchange or automated quotation system in which the person owned 2% or more of any class of outstanding stock, limited partnership units or other equity interests.

- c. The name and address of each corporation for which such person served in the capacity of a director, officer or receiver.

Filing of Reports The financial interest statements shall be filed at the following times, but no person is required to file more than one financial interest statement in any calendar year.

1. Every person required to file a financial interest statement shall file the statement annually not later than May 1 and the statement shall cover the calendar year ending the immediately preceding December 31; provided that any (official, board members, etc.) may supplement their financial interest statement to report additional interest acquired after December 31 of the covered year until the date of filing of the financial interest statement;
2. Each person appointed to an office shall file the statement within 30 days of such appointment or employment.

Financial disclosure reports giving the financial information required in Section 3 on page 8 shall be filed with the Hospital Secretary and the Missouri Ethics Commission. The reports shall be available for public inspection and copying during normal business hours.

Filing of Resolution: Annually, a conflict of interest resolution as stipulated in 105.454 shall be sent within ten (10) days of its adoption by the Board of Trustees to the Secretary of State's office. This resolution shall be in full force and effect from and after the date of its passage and approval and shall be renewed annually.

Outside Employment: Disciplinary action may be taken if an employee's performance is affected by another job or they are performing work duties for another employer while on duty at the Hospital.

Outside employment that constitutes any form of competition with the Hospital is not acceptable. Activities which, in the judgment of Administrator, are in conflict with the institution's objectives may constitute grounds for dismissal or other action.

Procurement of Services and Goods: It is the practice of the Hospital to initiate fee for service/supplies and/or contractual service/supply agreements on a fair and impartial basis. Any contract for a service/supply which is found by the Administrator and Board of Trustees to have been procured through the unfair influence of an employee may be terminated and re-bid. Such action by an employee may result in disciplinary action.

F. *Business Relationships*

Business transactions with vendors, contractors and other third parties shall be transacted free from offers or solicitation of gifts and favors or other improper inducements in exchange for influence or assistance in a transaction.

1. Employees and Trustees may not personally accept monetary gifts or gratuities from either patients or suppliers. However, the Hospital may conduct fundraising activities which are intended for charitable purposes. Soliciting monetary gifts for charitable purposes on behalf of the Hospital, the Liberty Hospital Foundation or the Liberty Hospital Auxiliary shall be permissible. Whenever monetary gifts or gratuities are offered by patients or suppliers, they should be gracefully declined. If a supplier or anyone else persists in offering monetary gifts, report such activity to the Compliance Officer. Employees or Trustees may accept occasional non-monetary gifts of a nominal value. Employees or Trustees who fail to comply are subject to disciplinary action which may include discharge. Likewise, gifts or gratuities may not be given by any individual representing the Hospital for the purpose of inducing or influencing referrals. Such gifts may constitute a violation of the law. Any questions about whether the gifts or gratuities may be received or given shall be referred to the Compliance Officer for review and approval.
2. ***Workshops, Seminars and Training Sessions.*** Attendance at local, vendor sponsored workshops, seminars and training sessions shall be permitted with prior approval by the employee's immediate supervisor or administration. Attendance at out of town seminars, workshops and training sessions, which are at the vendor's expense, is permitted only with the prior approval of the Compliance Officer.
3. ***Contracting.*** Business relations with contractors shall be conducted at arms length, both in fact and in appearance, and in compliance with the Hospital purchasing policies. Contractors shall disclose personal and business

relationships with the Hospital's employees and Trustees. Contracts shall be approved by the Administrator and/or the Board of Trustees subject to existing policies. The Hospital may from time to time engage legal counsel to conduct an independent review of its contracts.

4. ***Business Inducements.*** The Hospital shall follow the policy of not entering into contracts or financial arrangements that are designed to induce such referrals in violation of the anti-kickback statute, Stark self-referral law, or similar federal or state statutes or regulations. Furthermore, the Hospital shall not offer or provide gifts, other than non-monetary gifts of nominal value, free services, or other incentives to patients, relatives of patients, physicians, hospitals, contractors, nursing facilities, assisted living facilities, or other potential referral sources for the purpose of inducing referrals in violation of the anti-kickback statute, Stark self-referral law or other federal or state statutes or regulations. Business inducements which are intended to generate referrals may violate the law and are prohibited under this Plan.
5. ***Write-offs and Discounts.*** The Hospital shall discount standard charges when required by contractual agreements as permitted under federal and state law. The Administration may also adjust patient bills due to concerns about patient satisfaction issues. The Hospital shall make a reasonable collection effort on unpaid accounts, unless the patients are determined to be financially indigent. Those accounts that cannot be collected shall be written off according to Hospital's policies.

G. *Protection of Assets*

All employees and Trustees are responsible for the preservation and protection of the Hospital's assets. Employees shall make prudent and effective use of the Hospital's resources and accurately report their financial condition.

1. ***Internal Control.*** The Hospital has established control standards and procedures to provide that assets are properly used and that financial information is reported properly. Maintaining internal control standards is the responsibility of employees of the Hospital.
2. ***Financial Accounting and Reporting.*** It is the Hospital's policy to ensure that financial and accounting information is reported accurately, timely and completely. Improper or fraudulent reporting, documentation or accounting is contrary to the Hospital's policy and may be in violation of applicable laws. The following are examples of practices that shall be prohibited:
 - a. Falsifying either the reasons for any payment or documentation pertaining to any payment.

- b. Recording false entries on patient charts, claims forms or any other documents.
 - c. Billing for items or services not actually rendered.
 - d. Providing medically unnecessary services.
 - e. Using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient.
 - f. Billing using a Diagnosis Related Group (DRG) code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient.
 - g. Submitting duplicate claims or duplicate billing for reimbursement.
 - h. Submitting false cost reports.
 - i. Billing for services not covered or reimbursable.
3. ***Travel and Entertainment.*** Employees and Trustees shall obtain and maintain receipts for travel and entertainment expenses incurred while performing their job duties. It is the Hospital's policy that employees and Trustees shall not suffer or improperly gain financially as a result of performing their job duties. Employees and Trustees shall exercise good judgment in the use of the Hospital's assets and shall only request reimbursement for valid expenses that are reasonable, necessary and proper for the performance of the employee's job duties.
4. ***Personal Use of Corporate Assets.*** Employees and Trustees shall not convert the Hospital's assets to their own personal use. Employees and Trustees are prohibited from the unauthorized use or taking of the Hospital's equipment, supplies, furniture, materials or services. Any use of the Hospital's assets for purposes not related to services provided by the Hospital must be approved in advance by the Administrator.

H. *Background Checks*

A background investigation, including a reference check, shall be conducted before any new employee is hired. The investigation shall include a background check conducted by the Missouri State Highway Patrol or another qualified entity or agency as determined by the Hospital. The investigation shall also include, but not be limited to, an inquiry of the OIG Internet database containing information of the individuals who have been sanctioned by or excluded from participating in federally funded

health programs and any requirements set forth in the Hospital's guidelines. This review will be performed monthly by the Human Resources Department on all employees. Any employee appearing on the OIG Internet database shall be immediately reported to the Compliance Officer. The Compliance Officer shall determine appropriate remedial/disciplinary action and report such findings/actions to the Board of Trustees. Any applicant for such position shall be required to disclose any criminal conviction related to health care and action brought by any agency to exclude the applicant from participation in any federally funded program. Individuals who have been convicted of a criminal offense related to health care, or are listed by a federal agency as ineligible for participation in a federally funded program, shall not be employed by the Hospital. If criminal charges related to health care are brought against an individual or if a federal agency proposes to exclude an individual from participation in a federally funded health care program, such individual shall be removed from direct responsibility for or involvement in any federally funded health care program pending resolution of such charges. If resolution of the matter results in conviction, debarment or exclusion of the individual, the Hospital shall immediately terminate the individual's employment. The Hospital shall also conduct investigations of prospective members of the medical staff and its vendors and contractors as prescribed in the Hospital's policies. Furthermore, the Hospital shall conduct monthly inquiries of the OIG database for independent contractors providing service to the Hospital.

I. Legal Compliance

Hospital's employees are expected to be sufficiently knowledgeable of the legal aspects of their responsibilities and activities in order to reduce the risk of unintended legal violations. Hospital's employees whose positions may impact the Hospital's compliance with laws and regulations will attend training and educational opportunities offered by the Hospital and pursue a reasonable amount of continuing self-education. It is the responsibility of all Hospital employees to notify their supervisor when they have a question regarding the legal aspects of their job and when additional information is needed. If questions arise regarding the existence, applicability or interpretation of any law, the Compliance Officer should be contacted.

Hospital's employees are required to comply with applicable laws and regulations related to their job responsibilities and to refrain from knowingly participating in illegal activities or failing to meet affirmative legal duties whether or not specifically addressed in these Hospital Standards of Conduct.

Hospital's employees are expected to comply with applicable antitrust and similar laws that regulate competition. Examples of prohibited conduct include: (1) agreements with competitors to fix prices; (2) organized boycotts of governmental or other payors; and (3) unfair trade practices.

III. Compliance Officer and Committee

A. Appointment of a Compliance Officer

The Plan shall be directed by a Compliance Officer. The Board of Trustees has appointed the Assistant Administrator, Information & Support Services as the Plan's Compliance Officer and he shall serve at their discretion for a one-year term and continue for annual, one-year renewals until a successor is named by the Board of Trustees. In the event the Assistant Administrator, Information & Support Services shall be replaced as the Compliance Officer, the newly appointed Compliance Officer shall be an executive officer or another high level official of the Hospital. The Compliance Officer shall report directly to the Board of Trustees. Any change in the person responsible for administering this Plan shall be approved by the Board of Trustees. The Compliance Officer may appoint a designee during temporary absences. The Administrator shall temporarily serve as the Compliance Officer in the event the Assistant Administrator, Information & Support Services, is implicated in a report.

B. Duties of the Compliance Officer

The Compliance Officer's duties shall include the following:

1. Oversee and monitor the Hospital's compliance activities.
2. Meet periodically with the Compliance Committee and report to the Board of Trustees at least semi-annually on the progress of the Plan.
3. Ensure that the Plan has been properly implemented and that revisions are made as appropriate.
4. Periodically review the Plan and recommend revisions as necessary to meet changes in the business and regulatory environment.
5. Coordinate compliance training and related educational activities for the Hospital employees and additional Parties as required.
6. Review and update education or training materials to reflect current laws and regulations applicable to health care programs.
7. Coordinate internal auditing and monitoring of activities within the scope of the Compliance work plan.

8. Review compliance in departments on a periodic basis as needed.
9. Coordinate the drafting and updating of standards of conduct, policies and procedures.
10. Coordinate the review of contracts with independent contractors and agents and, with regard to contracts with physicians or physician entities, coordinate with legal counsel on review of such contracts and assure submission of such contracts to the Board of Trustees for its review and approval.
11. Ensure that the Plan has been effectively communicated to present and new employees of the Hospital.
12. Receive and investigate reports of conduct that violates the Standards of Conduct and with regard to reports of possible illegal conduct coordinate with legal counsel on investigation of possible illegal conduct.
13. Establish and administer a communication system that shall be available to employees to report any suspected illegal conduct or other conduct that violates the Standards of Conduct without fear of retribution or retaliation.
14. Notify appropriate law enforcement agency(ies) of possible illegal misconduct if so directed by the Board of Trustees.
15. Act as Chair of the Compliance Committee appointed in accordance with Section III (C) of this Plan.

C. Appointment of a Compliance Committee

The Administrator shall appoint a Compliance Committee comprised of the Administrative Team and key department members of the Hospital. The Administrative Team shall have a “standing” status while other members shall be appointed for a one-year term, subject to reappointment.

1. The Compliance Committee members shall work with the Compliance Officer in the design, implementation and ongoing review of their departmental participation in the Plan. Committee members may participate in reviews or audits of department activities and assist in developing specific standards of conduct and policies and procedures. The Committee members shall also coordinate compliance training, relay compliance related communications, and monitor compliance efforts in their department. The Committee members shall report to, and coordinate with , the Compliance Officer with respect to compliance related activities in their department. The Compliance Officer

shall be responsible to work with the managers and supervisors from other departments to ensure their participation in and compliance with the Plan.

2. To assure proper coordination of the compliance effort, the Compliance Committee shall meet periodically to discuss, review and resolve compliance issues. The Compliance Committee's functions shall include, but not be limited to:
 - a. Analyze business and legal requirements with which the Hospital must comply;
 - b. Assess existing policies and procedures to determine their adequacy in meeting the Hospital's objectives;
 - c. Conduct periodic risk assessments and review the results of internal audits;
 - d. Develop new standards of conduct, policies and procedures and recommend and monitor the development of internal systems and controls to promote compliance;
 - e. Assist in developing work plans to address potential compliance issues uncovered in the course of conducting risk assessments or audits;
 - f. Determine the appropriate approach/strategy to promote compliance with the Plan and detection of any potential violation;
 - g. Maintain a system to solicit, evaluate and respond to complaints and problems;
 - h. Perform such special projects as requested by the Compliance Officer.

D. Hospital's Managers and Supervisors

Managers and supervisors have a responsibility to know and understand the laws and regulations that apply to their area of responsibility and to exhibit a strong commitment to compliance. Based upon their knowledge of laws and regulations and the identification of compliance risk factors, they will develop and implement internal controls to provide reasonable assurance that the employees they supervise comply with laws and regulations. The level of compliance within their area of responsibility will be monitored using measures identified with the Compliance Officer. Managers and supervisors will encourage open communication among employees concerning compliance matters. Managers and supervisors will evaluate the compliance

performance of employees during their annual review and will use due diligence in hiring and retaining employees.

IV. Education and Training

The Plan shall require training and education for employees so that each has a clear understanding of their responsibilities and rights under the Plan. The education and training shall emphasize the Hospital's commitment to compliance with laws, regulations and guidelines governing health care programs. Failure to comply with training requirements or to attend scheduled training sessions of the Hospital or of each department may result in disciplinary action or loss of affiliation. It is not necessary, however, that every employee be educated concerning every aspect of the Plan.

The Compliance Officer shall determine, in cooperation with the Compliance Committee, the materials and the training that each classification of employee shall receive. Each employee shall receive a copy of the relevant portions of the Compliance Plan. Employees will complete a Compliance computer based learning (CBL) module during new employee orientation. A competency validation tool and employee acknowledgement is part of this CBL. Tracking of compliance employee education is the responsibility of the Education Department. The Compliance Officer shall promptly respond to any questions of each employee regarding the compliance materials.

A. Other Training and Education

In addition to the new employee orientation Compliance CBL, the Compliance Officer or a designee shall provide for additional training (e.g. seminars, live or videotaped presentations, or more detailed written materials) in targeted departments covering specific issues identified by the Compliance Committee. Such training shall utilize in-house expertise whenever possible. However, the Compliance Officer may request the services of outside experts to conduct specialized or highly technical training.

B. Government Compliance Alerts and Guidance Rules

The OIG and other government agencies periodically publish fraud and abuse alerts, interpretations and compliance guidance regulations. The Compliance Officer or a designee shall distribute copies of this material to the Compliance Committee and to other affected employees as deemed appropriate. Of particular importance are the compliance guidance regulations which are published by the OIG which include the Hospital compliance guidance, the home health agency compliance guidance, the laboratory compliance guidance and the third party billing compliance. In identifying potential risk areas and developing or revising policies and procedures to strengthen controls over these areas, the Compliance Officer or a designee shall further ensure

that affected employees receive the HCFA, Intermediary, Carrier and other agency manual revisions, instructions, regulations, bulletins or other material which is considered necessary to properly perform their job duties and responsibilities. Additionally, all Hospital employees shall receive training regarding fraud and abuse reporting and protection from retaliation.

C. Competency Assessment/Recordkeeping

Education and training is part of the Hospital's competency assessment program. The Compliance Officer or designee shall enlist the assistance of the HR department and others for education and training relating to compliance issues. The HR Department, with the input of each affected department, shall develop an appropriate education competency assessment for affected employees. An employee's competency shall be evaluated in orientation and throughout employment. Documentation of the competency validation shall be retained by the Hospital in accordance with its record retention program.

D. New Employees

New employees shall receive the compliance materials relative to their job duties as a part of their orientation.

V. Testing and Monitoring

To detect areas of potential noncompliance and improve the quality of the work product, an ongoing evaluation process is very important to the success of the Hospital's compliance plan. The Hospital shall conduct the following testing and monitoring process:

A. Periodic Testing

The Hospital shall have an annual financial audit conducted by an independent public accounting firm. In addition, the Hospital shall schedule periodic testing of targeted areas to determine if they are in compliance with the procedures and standards of conduct established in this Plan. Examples of such testing shall include but not be limited to:

1. Charge Description Master reviews
2. Medical record reviews
3. Billing and coding reviews
4. Cost report reviews
5. Human resource reviews
6. Tax reviews

Such testing shall be coordinated by the Compliance Officer or a designee. Whenever possible, such testing shall be conducted by in-house personnel. However, under certain circumstances, the Compliance Officer may engage outside auditors per Hospital policy. The Compliance Officer may seek the advice of legal counsel before engaging the outside auditors.

B. Testing Techniques

The Compliance Officer and staff or external auditors shall consider techniques such as the following:

1. Interviews of personnel involved in management, operations, billing and other related activities.
2. Reviews of written policies and procedures prepared by the different departments of the hospital.
3. Analytical or comparative reviews.
4. Examinations of supporting documents and records.
5. Surveys or questionnaires.
6. On-site visits.

C. Other Monitoring

1. On an annual basis, the Compliance Officer may retain an independent firm to review records and reports, which are required to be maintained in accordance with the provisions of this Plan.
2. Copies of correspondence relating to audits, denials, differences, surveys, complaints, investigations or inquiries from an organization administering a health care program shall be immediately copied and directed to the Compliance Officer.

D. Investigations and Corrective Action

If an audit discloses potential violations or misconduct, the procedures outlined in Article IX and X of this Plan shall be followed. In addition, the Compliance Officer shall, with assistance of the Compliance Committee, ensure that policies and

procedures are updated and additional training is provided where necessary to prevent continued noncompliance.

VI. Effective Lines of Communication for Employees

A. Employee's Responsibility

Employees of the Hospital shall have the following responsibility with respect to this Plan:

1. To report to the Hospital as truthfully and factually as possible violations of the law occurring within the Hospital or involving the Hospital's assets, or any violations of the standards contained in this Plan.
2. To seek clarification of any questions the employees may have with this Plan on their job duties.
3. A question which cannot be resolved internally, that involves billing, coding, documentation, or reimbursement matters shall be reported to the appropriate agency.
4. To cooperate fully with the Board of Trustees and the Compliance Officer and their agents in their efforts to implement and maintain the Plan.
5. To cooperate fully in any investigations or audits conducted in connection with this Plan.

B. Reporting Mechanisms

An employee shall report in good faith their belief of violations of the Plan or applicable laws, or seek guidance regarding any questions he or she may have with regard to the Plan or the carrying out of their job duties, as follows:

1. By contacting the employee's supervisor to determine if it is a compliance issue or not. This procedure should not be followed if the complaint involves the employee's supervisor.
2. By calling the Assistant Administrator of Human Resources or designee on the Compliance Hot Line at 407-2000 and leaving a detailed message. The hotline number shall be posted on bulletin boards throughout the Hospital. Such calls may be made anonymously. The hotline should be checked daily Monday through Friday.
3. By requesting a private meeting with the Compliance Officer.

4. By mailing their written question/concern to:

Mr. David H. Feess
Compliance Officer
Liberty Hospital
2525 Glenn Hendren Drive
Liberty, Missouri 64068

The investigation of complaints shall be initiated within two business days. Notification shall be provided to the reporting employee (if known) that the report has been received and is being reviewed. Reports shall be taken seriously and shall be responded to as soon as possible.

C. Questions or Concerns

Upon receipt of a question or concern about a compliance related issue, the employee's supervisor or the department manager shall promptly deliver a report of the question or concern to the Compliance Officer. However, if the supervisor or the department manager believes that the question or concern involves an allegation of a violation of the law or the Plan by the Compliance Officer, the question or concern shall be delivered immediately to the President of the Board of Trustees.

D. Recordkeeping

A record shall be made of each report received by the Compliance Officer or a designee on a form prepared for this purpose. The Compliance Officer or a designee shall record information pertaining to the report which is necessary to conduct an appropriate investigation. This information shall include pertinent details relating to the reported incident including the time and date, person or persons involved in the incident, description of the incident, results of the investigation and final disposition of the complaint or inquiry. If the employee or other person was seeking information regarding the Standards of Conduct or some other matter such as their job duties, the Compliance Officer or a designee, shall record the nature of the call or report and the information requested and shall respond to the employee as soon as possible if their name is known.

E. Retaliation

Any threat of discrimination against, retaliation against, dismissing or in any manner penalizing a person who acts pursuant to their responsibilities under the Plan is not only against the Hospital's policy, but also in some instances, is a violation of the law. Retaliation, if proven, shall be subject to appropriate discipline. Employees,

who in good faith, report potential compliance issues shall not be retaliated against. However, employees who file false or misleading claims shall be subject to disciplinary action. In addition, employees who report acts of misconduct or violations that they have committed shall not be immune from disciplinary action.

F. False Report

Any attempt to harm or slander another through false accusations, malicious rumors or other irresponsible actions are a violation of the Hospital's policy. Such attempts, if proven, shall be subject to discipline or loss of affiliation.

G. Confidentiality

The Hospital, at the request of an employee making a report, shall provide such anonymity to the employee as is possible under the circumstances provided such confidentiality is, in the judgment of the Compliance Officer, consistent with the Hospital's obligation to investigate employee concerns and take necessary corrective action. However, the Hospital cannot provide any assurances of anonymity if an external investigation is performed.

VII. Enforcing Employee Standards through Well Publicized Disciplinary Guidelines

Employees shall be disciplined who have failed to comply with the Hospital's standards of conduct or Federal and State laws governing health care programs. Those who have otherwise engaged in wrongdoing that has the potential of impairing the Hospital's status as a reliable, honest and trustworthy health care provider shall also be subject to disciplinary action.

A. Management Responsible for Discipline

The Compliance Officer, in consultation with the Assistant Administrator Human Resources and/or the department manager, shall establish procedures for the discipline of employees because of violations of the Plan and the Standards of Conduct contained in the Plan.

B. Persons involved in Improper Activities

Any employee who violates the Plan or the Standards of Conduct contained in the Plan shall be appropriately disciplined as provided by the Hospital's personnel policies. Violations include the failure to report suspected improper activity. Disciplinary action may range from a warning to termination and may include mandatory training. Any disciplinary action shall be appropriately documented in the

employee's personnel file, along with a statement of the reasons for imposing such discipline.

C. Reports to the Board

The Compliance Officer shall report at least annually to the Board of Trustees regarding disciplinary actions involving the Plan.

VIII. Investigations of Potential Noncompliance

Upon receipt of audit results, reports or complaints suggesting possible noncompliance with the laws or rules of Medicare, Medicaid, other federal or state health care programs, or private health care plans or contracts, the Hospital shall follow the investigation policies and procedures set forth below:

- **Purpose of Investigation.** The purpose of the investigation shall be to identify those situations in which the laws, rules or standards of Medicare, Medicaid, other federal or state health care programs, or private health care plans or contracts may not be followed; to identify individuals who may have knowingly or inadvertently caused claims to be submitted or processed in a manner which violates applicable laws, rules or standards; to facilitate the correction of any practices not in compliance with the applicable laws, rules or standards; to implement those procedures necessary to ensure future compliance; to protect the Hospital in the event of civil or criminal enforcement actions and to preserve and protect the Hospital's assets.
- **Control of Investigations.** The Compliance Officer shall be responsible for directing the investigation of the alleged problem or incident. At the discretion of the Compliance Officer, the information or report received may be forwarded to legal counsel who may assist in the investigation of the alleged problem or incident. In conducting an investigation, the Compliance Officer or legal counsel may request the support of Hospital's staff, internal counsel and auditors, consultants, and other external resources with the technical expertise or knowledge to assist with the specific problem or incident. These persons shall function under the direction of the Compliance Officer or legal counsel and shall be required to submit relevant evidence, notes, findings and conclusions to the Compliance Officer or legal counsel depending upon who is directing the investigation.
- **Investigative Process.** The following steps are not all inclusive but are the basic procedures to be undertaken:
 - a. Interviews of the persons who may have knowledge of the alleged problem or process and a review of the applicable laws and regulations which might be

relevant to or provide guidance with respect to the appropriateness of the activity in question, to determine whether or not a problem actually exists.

- b. A review of representative bills or claims submitted to or under the Medicare, Medicaid, other federal or state program, or private health care plan or contract, and/or relevant contracts, cost reports, invoices, ledgers and other documents, to determine the nature of the problem, the duration of the problem, and the potential financial magnitude of the problem.
- c. Interviews of the person or persons who appeared to play a role in the process or who have knowledge of the problem. The purpose of these interviews shall be to determine the facts related to the alleged problem or incident as opposed to making judgments and may include the following steps:
 - (1) The understanding of the applicable laws, rules and regulations of the person or persons involved in the situation;
 - (2) The identification of persons with supervisory or managerial responsibility in the process;
 - (3) The adequacy of the training of the individuals performing the functions within the process;
 - (4) The extent of which any person knowingly or with reckless disregard or intentional indifference acted contrary to the applicable laws, rules or regulations;
- d. Preparation of a summary report which (i) defines the nature of the problem, (ii) summarizes the investigation process, (iii) identifies any person whom the investigator believes to have either acted deliberately or with reckless disregard or intentional indifference toward the applicable laws, rules and policies, and (iv) if possible, estimates the nature and extent of the resulting overpayment by the government, if any.
- e. If the review results in conclusions or findings that the conduct is permitted under applicable laws, regulations or policy or that the alleged problem or incident did not occur, the investigation shall be closed.
- f. If the investigation concludes that there is improper billing occurring, that practices are occurring which are contrary to applicable law or, that inaccurate claims are being submitted, corrective action shall be taken in accordance with Section IX.

- g. If the identity of the person or persons filing the complaint is known, the Compliance Officer shall report to that person or persons that an investigation has been completed and, if appropriate, the corrective action shall be taken.

IX. Organizational Response

If, upon conclusion of an investigation, it appears that there are genuine compliance concerns, the Compliance Officer shall immediately formulate and implement a corrective action plan. The corrective action plan shall be designed to ensure that the specific issue is addressed and, to the extent possible, that similar problems do not occur in other departments or areas. The procedure for undertaking corrective action shall include, but need not be limited to the following:

A. Possible Criminal Activity

If the investigation uncovers what appears to be criminal activity on the part of any employee or other party, the Hospital shall:

1. Notify legal counsel and the President of the Board of Trustees.
2. Immediately stop billing or other activities related to the problem until such time as the offending practices are corrected.
3. Initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent or with reckless disregard. Appropriate disciplinary action shall include, at minimum, the removal of the person from any position with oversight for or involvement with the claims submission or billing process and may include, in addition, reprimand, suspension, demotion, or discharge.
4. Notify the appropriate law enforcement or regulatory authorities with the advice of legal counsel no later than 60 days after credible evidence has been obtained to confirm that a violation has occurred.
5. Modify the applicable policies and procedures.
6. Undertake an appropriate program of education to prevent similar noncompliance in the future.
7. Take any other action deemed appropriate under the circumstances.

B. Other Noncompliance

If the investigation reveals problems which do not appear to be the result of conduct which is intentional, willfully indifferent, or with reckless disregard, the Hospital shall undertake the following steps:

1. Improper Payments. If the problem results in duplicate payments by Medicare, Medicaid, other federal or state health care programs, or private health care plans or contracts, coding or claims submission errors, payments for non-covered services or for services not rendered or provided other than as claimed or any other type of overpayment resulting from billing or payment errors, the Hospital shall:
 - a. Stop billing or other activities of the type which is a problem until such time as the offending practice is corrected;
 - b. Determine, in consultation with legal counsel and the President of the Board of Trustees, the need to calculate and repay the overpayments to the appropriate Fiscal Intermediary, Carrier, or other payers.
 - c. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, demotion, suspension or discharge; and
 - d. Promptly undertake an appropriate program of education to prevent future similar problems.
 - e. Modify the applicable policies and procedures.
2. No Improper Payment. In the event the problem does not result in an improper payment by Medicare, Medicaid, and other federal or state health care program, or a private health care plan or contract, the Hospital shall:
 - a. Correct the defective practice or procedure as quickly as possible by finding the real problem and resolving it with the proper solution.
 - b. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action shall be consistent with Hospital's guidelines.
 - c. Promptly undertake an appropriate program of education to prevent future similar problems.

C. Future Actions

Any issue for which a corrective action plan is implemented shall be reviewed in future audits of the affected department or area. The Compliance specifically targeted for monitoring and Officer shall periodically report to the Board of Trustees on the nature of the investigations that have been conducted, the findings, the corrective actions and the repayment, if applicable, of funds to Federal, State or other agencies.

X. Record Retention

The purpose of the record retention policy is to provide guidelines as to the creation, maintenance, retention and destruction of documents, and to establish a mechanism for periodic review of the retention periods and of the Hospital's compliance with requirements of this policy and of applicable document retention periods specified by law or regulation. The Hospital shall follow the record retention requirements required by applicable laws, regulations, and contractual agreements. It is expressly prohibited to alter documents to deceive another person or entity, to conceal information to distort the truth, to destroy records to hide the facts or to obstruct an investigation in any way by tampering with the Hospital's records.

Corporate Compliance Plan

HISTORY:

01/07	Revised	D Feess
11/06	Revised	D Feess
09/06	Approved	Board of Trustees
09/06	Revised	J Crossett
04/05	Revised	
	Approved	Board of Trustees
06/03	Revised	Corporate Compliance Committee

APPROVAL:

DATE:

Joseph W. Crossett, Administrator

Board of Trustees President