Harmony Healthcare Long Island

COMPLIANCE PROGRAM

Compliance Protocols

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I. COMPLIANCE PROGRAM IMPLEMENTATION

A. Governance and Control Authorization. The Board of Directors of the Harmony Healthcare Long Island (the "Facility") have authorized the adoption of a compliance program consisting of a written plan for assuring compliance with the various laws and regulations affecting the Facility's operations. This program is designed to include: (1) Compliance Protocols; (2) Compliance Manual; and (3) other appropriate policies and procedures affecting any risk area in the Facility's operations. Together, these documents constitute the Facility's Compliance Program (the "Program").

B. Access and Custody. Access to these Compliance Protocols and policies developed under the Compliance Program will be available to all affected individuals in the Facility's compliance system, MedTrainer ("Compliance System"). The compliance System shall include:

1. The official authorized version of the Compliance Protocols;
2. The approved version of the Compliance Manual;
3. Copies of policies and procedures adopted by the Company and subject to the Compliance Program to date; and
4. Copies of all appropriate forms and applicable policies to be utilized under the Compliance Program

C. Authorizations, Modifications and Amendments. All authorizing resolutions regarding the Compliance Program shall be maintained in the Compliance Committee minutes and Board of Directors meeting minutes. The Compliance Protocols and/or Compliance Manual may be amended and/or modified by the Compliance Officer and/or Compliance Committee as needed to ensure efficient and up-to-date operation of the Compliance Program, provided that notice of such amendment or modification is approved at the next regularly scheduled meeting of the Board of Directors.

Any changes to the Corporate Compliance Program, including the protocols, compliance manual or policies shall be properly archived in the Compliance System.

D. Corporate Governance. The governing authority of the Facility will review all issues affecting governance of the Facility through standing committees and committees of the corporation as warranted under the Standards of Participation set forth under Federal Law, the requirements of the Public Health Law and regulations, as well as the Facility's Compliance Program. The licensed entity and Operator of the Facility is a Federally Qualified Health Center Article 28 and Sunny Brown as the Compliance Officer is an authorized designee of the Board pursuant to this Compliance Manual.

II. COMPLIANCE COMMITTEE

A. Composition. The Compliance Committee shall be set forth on a Compliance Contact Sheet to the Compliance Manual and except as modified on such Compliance Contact Sheet, will consist of the Facility's:

1. Compliance Officer & Vice President of Human Resources
2. Chief Operating Officer
3. Chief Medical Officer& Risk Manager
4. Chief Financial Officer
5. Chief Executive Officer

B. Meetings. The Compliance Committee shall meet quarterly and more frequently if deemed necessary. Prior to such meetings, the Compliance Officer shall submit to each member of the Committee an agenda enumerating matters to be reviewed by the Committee. The CEO or the Compliance Officer may call special meetings of the Compliance Committee. Members of the Compliance Committee may participate in meetings either in person or by telephonic communication.

C. Quorum. The presence of at least a majority of the members of the Compliance Committee shall constitute a quorum. All actions by the Compliance Committee require a majority vote of the members present. The Compliance Officer shall be responsible for communicating the Compliance Committee's actions and recommendations to employees, when necessary or required.

D. Duties and Functions. The Compliance Committee's duties and functions are to:

1. Analyze the Facility's business environment, including the legal and regulatory requirements thereof, and identify and determine specific areas of potential risk to be addressed in the Facility’s Compliance Program;

2. Assess existing internal systems and controls in these areas to determine if same are effective for detecting and preventing illegal or unethical conduct;

3. Under the direction of the Compliance Office and in conjunction with relevant department heads, revise internal systems and controls where necessary and develop internal systems and controls where needed and monitor compliance with such internal systems and controls;

4. Determine those departments or job responsibilities for which periodic training and education is necessary and, under the direction of the Compliance Officer, ensure that such periodic training and education is carried out;

5. Under the direction of the Compliance Officer and in conjunction with relevant department heads, develop, establish and revise, as necessary, policies and

procedures to promote compliance with applicable laws, regulations and ethical standards, including but not limited to policies on the areas set forth in Article I .2 of these Protocols, a Self Disclosure Policy and policies required under the Deficit Reduction Act of 2005 relating to educational requirements for the prevention of fraud, abuse and waste under the Medicaid program;

6. Under the direction of the Compliance Officer, ensure the development of internal auditing procedures with respect to specific areas of potential risk;

7. Under the direction of the Compliance Officer, ensure the development and implementation of initial, annual and periodic training and education sessions;

8. Under the direction of the Compliance Officer, review and investigate reported suspected violations of legal, regulatory or ethical standards and recommend to administration appropriate corrective actions, if required, including but not limited to disciplinary action and self-reporting to state or federal governmental agencies;

9. Review and recommend revisions, as necessary, with regard to the Compliance Program, the Compliance Protocol and the Compliance Manual;

10. Ensure that sufficient funding is available for the Compliance Officer to carryout the day to day operations of the Compliance Program.

E. Reporting. The Compliance Committee shall report, at least quarterly, to the Facility's governing authority and Established Operators with regard to activities of the Compliance Committee including, but not limited to, any investigations and responses thereto conducted during the reporting period. An annual report will be provided and will form the basis for the Facility's annual compliance review and certification as to the effectiveness of the overall Compliance Program.

III. COMPLIANCE OFFICER

A. **Appointment.** The Compliance Officer must be an individual within high level personnel of Agency and an employee of the Facility. The Compliance Officer will be appointed by the Established Operator or authorized designee.

B. **Duties and Responsibilities.** The Compliance Officer is responsible for the day to day operation of Facility's Compliance Program. The Compliance Officer shall be responsible for:

1. Reporting on a regular basis to Facility's Compliance Committee and Established Operator on the progress of the implementation, development and operation of the Compliance Program;

2. Recommending to the Compliance Committee revisions to the Compliance Program when needed in light of changes in legal, regulatory and ethical standards;

3. Developing and implementing, in conjunction with relevant department heads and outside consultants, if necessary, the initial, annual and periodic training and education program;

4. Ensuring that independent contractors and agents who provide services or supplies to Facility are aware of the requirements of Facility's Compliance Program;

5. Developing, implementing and placing in operation, in conjunction with relevant department heads and outside consultants, if necessary, internal audit and control systems with respect to departments or areas determined to be areas of potential risk, including annual or periodic reviews thereof;

6. Investigating all reported suspected violations of legal, regulatory or ethical standards, report the results of such investigation to the Compliance Committee and recommend to the Compliance Committee appropriate follow up action, including but not limited to disciplinary action and self-reporting to appropriate state or governmental agencies. In undertaking an investigation, the Compliance Officer, subject to the approval of the Compliance Committee, may engage outside legal and/or accounting experts;

7. Developing, implementing and placing in operation reporting mechanisms which can be utilized by Facility's employees and professional staff to report suspected violations of legal, regulatory and ethical standards;

8. Developing and implementing a record keeping system with regard to:

    i) distribution to employees, professional staff and providers of supplies and services to Facility of Facility's Compliance Manual and all updates and revisions thereto;

ii) employee and professional staff attendance at all required initial, annual and periodic education and training programs;

iii) verification of receipt of reports of suspected violations of legal, regulatory or ethical standards;

iv) conducting of investigations, including the results thereof and any corrective actions taken in response thereto;

9. Assembling a database of compliance information for use in education and training and updating and revising the Compliance Program, including but not limited to the Office of the Inspector General's Management Advisory Reports, Special Fraud Alerts issued by the Office of the Inspector General, Advisory Opinions issued by the Office of the Inspector General, the Inspector General's annual work plan, coding requirements and billing requirements of appropriate state and federal agencies, including those of their respective fiscal intermediaries. For example, sources such as the OIG audit plan, the OMIG statement of audit and investigations, along with OASAS standards and the NY Medicaid Update posted on the New York State Department of Health Website and Medicaid Alerts as posted on governmental websites should be accessed and reviewed regularly. Such databases should be updated on at least a monthly basis.

10. Acting as the central person responsible for obtaining and coordinating any governmental or payor inquiries and/or enforcement actions. The Compliance Officer shall not take the place of the Administrator, CFO or other designated individual with regard to the initial receipt and/or access to secure government communications (unless otherwise appointed as such), however, the Compliance Officer has the responsibility or ensuring that all such designated individuals immediately provided relevant information to coordinate appropriate review, investigation and responses.

C. **Access.** In carrying its responsibilities hereunder, the Compliance Officer and/or those individuals designated by the Facility's Operators, shall have the authority to review all documents and other information that is relevant to compliance activities, including, but not limited to, medical records, billing records, employment and vendor contracts. The Compliance Officer shall also have authority to access, as necessary, the Facility's employees, professional staff members and vendors. The Compliance Officer will be expected to coordinate all internal compliance reviews, monitoring activities and act as liaison with applicable federal and state representatives in charge of compliance activities as needed.

D. **Outside Consultants and Experts.** The Compliance Officer, with the prior approval of the Chief Executive Officer, shall have the authority to engage outside counsel including legal and accounting, when necessary for the Compliance Officer to fulfill his/her responsibilities hereunder.

E. Governmental Contacts. The Compliance Officer will also maintain a list of governmental contacts (websites) for purposes of implementing any reporting mandates or self disclosure requirements under the Compliance Program. This list will include the following and as updated regularly:

1. US Department of Health and Human Services, Office of the Inspector General
2. US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS)
3. New York OMIG self reporting contacts
4. New York DOH contacts regarding advisory opinions
5. New York Attorney General and Medicaid Fraud Control Uni

IV. EDUCATION AND TRAINING

In developing the training and education component of Facility's Compliance Program, the following principles will be adhered to:

1. Initial and annual training and education programs should concentrate on Facility's Compliance Program as outlined in the Compliance Manual, ethical standards and conflicts of interest and basic federal and regulatory standards governing Facility's business. Training and education shall include all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member.

2. In addition to those specific areas which the Compliance Committee has determined appropriate for periodic training, periodic training and education programs shall be developed in the following areas:

   (a) Federal and state statutory and regulatory standards affecting Facility's business;

   (b) Policies and procedures of private payors;

   (c) Coding requirements, including proper completion reporting forms;

   (d) Claim development and submission processes;

   (e) Fraud and abuse;

   (f) Governmental reimbursement principles;

   (g) Prohibitions on alteration of medical/financial records;

   (h) Proper documentation for services rendered & Confidentiality;

   (i) Payment issues.

   (j) Survey Compliance, Medical necessity and quality of care;

   (k) Governance;

   (l) Mandatory reporting;

   (m) Credentialing;

(n) EMR, IT, HIPAA Standards; and

(o) Other risk areas that are or should with due diligence be identified by the Facility.

3. In developing the initial, annual and periodic training and education programs and sessions, the Compliance Officer is encouraged to seek the input from department heads and the in-service coordinator. In addition, the Compliance Officer is authorized to utilize the services of outside consultants, including provider associations, fiscal intermediaries and governmental agencies;

4. Documentation assembled by the Compliance Officer should be incorporated in the education and training program and sessions;

5. Periodic dissemination of information and/or training and education sessions should be undertaken as soon as practicable upon the receipt of information or documentation of new or revised standards affecting the Compliance Program (for example, in the event a special fraud alert is issued by the Office of the Inspector General affecting the nursing home industry, the Compliance Officer should undertake as soon as practicable thereafter to disseminate the information to affected employees and staff and, if determined necessary, schedule an appropriate periodic training session).

6. Deficit Reduction Act 2005 Educational Requirements. If the Facility receives more than $5 million annually from participation in Medicaid payor programs, then all employees, vendors, and agents doing business or providing services on behalf of the Facility must receive a summary of applicable statutes and regulations concerning false claims, administrative and civil penalties relating to health care programs. Such summaries will include both federal and state requirements as well as a summary of whistleblower protections relating thereto. The compliance committee will update and revise such summaries in accordance with 42 USC § 1396a(a)(68) as well as section 363-d(c) of the New York State Social Services Law. The compliance officer shall insure that such summaries and any revisions thereto are distributed to all employees, vendors, agents of the Facility.

V. EMPLOYMENT

A. Prohibition. The Facility is prohibited from employing any individual who has been:

1 . Convicted of a criminal offense relating to health care, including: conviction for a criminal offense relating to delivery of an item or service under Medicare or a state health care program, conviction for a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or services, conviction for an offense relating to health care fraud and conviction for an offense relating to obstruction of an investigation of a criminal offense related to the delivery of an item or service under Medicare or a state health care program; and

2. Debarred, excluded or otherwise ineligible for participation in a federal health care program which is defined as any plan or program that provides health benefits whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States government or any state health care program.

B. Employment Application. The Facility's employment application will, to the extent necessary, be modified to require each applicant to disclose any conviction for a criminal offense related to health care or any debarment, exclusion or ineligibility of the applicant for participation in a federal health care program. Similarly, the facility's application for staff privileges will, to the extent necessary, be modified accordingly.

C. Background Checks. With regard to applications for employment for positions with discretionary authority to make decisions that may involve compliance with law or compliance oversight, the Facility shall conduct an appropriate reference check and diligently review appropriate and available resources to assure that the individual is not disqualified from serving in such position. In addition the Facility will conduct criminal background checks in accordance with New York State's standards and as required by law. The Facility will review information maintained on line by the Federal General Services Administration and New York OMIG containing a monthly listing of the debarred individuals. Internet accessible as follows:

US GSA	https://www.sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf
OIG	https://exclusions.oig.hhs.gov/
NY OMIG	http://www.emedny.org/info/disqualified.html

D. Evaluations. Promotion of and adherence to compliance shall be an element in evaluating the performance of administrative and supervisory staff. Annual evaluation reports for administrative and supervisory staff will be modified to incorporate a compliance component by including the following language:

> **Corporate Compliance** Employees of the HHLI are expected to adhere to the HHLI Compliance Program by attending all appropriate training programs, assuring that corrective actions are strictly implemented in their particular areas of employment and by exhibiting an awareness of

compliance in all aspects of their job duties and assignments. Has the employee diligently completed compliance trainings and shown appropriate regard for compliance issues?

E. Subcontractors Credentialing and Training Certifications.

1. Provision of contracted services shall be in accordance with the contracting standards set forth by Department of Health regulations governing such contracts.

2. Documentation standards shall also be maintained for all outside contracts who must be professionally licensed in order to assure that the Facility is utilizing properly licensed and trained independent contractors.

F. Professional Privileges. All credentialing of medical and other professionals for purposes of admission privileges and/or treatment access privileges shall be performed in accordance with the requirements and standards set forth in paragraph E(2) above and the credentialing policies and protocols of the Facility. Such persons shall also be subject to the background checks set forth in paragraphs A and C above.

G. Disciplinary Matters; Non-Retaliation/Non-Intimidation. All covered persons and the Facility's Human Resources staff will be trained on the importance of disciplinary measures required in instances where employees, vendors or other applicable personnel fail to report or adhere to the obligations set forth in the Compliance Manual or compliance responsibilities. Training and orientation will also include disciplinary measures required to ensure that persons in positions of authority, supervision and those engaged with individuals who report matters are not retaliated against or intimidated for submission of concerns or reports of violations. This includes ensuring that there is no intimidation of covered persons from reporting violations or raising concerns.

VI. VENDOR AND PROFESSIONAL CONTRACTS

A. **Prohibition.** The Facility is prohibited from entering into a contract with any individual, company or entity which has been:

1. Convicted of a criminal offense relating to health care, including conviction for a criminal offense relating to delivery of an item or service under Medicare or a state health care program, conviction for a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or services, conviction for an offense relating to health care fraud and conviction for an offense relating to obstruction of an investigation of a criminal offense related to the delivery of an item or service under Medicare or a state health care program; and

2. Debarred, excluded or otherwise ineligible for participation in a federal health care program which is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States government or any state health care program.

B. **Background Checks.** Before entering into any vendor or professional service contract, the Facility will require each vendor and professional provider to sign a certification to the effect that the vendor has not been convicted of a criminal offense relating to health care or been debarred, excluded or otherwise found ineligible to participate or engage in any work involving a federal health care program. Such certification shall be maintained in the appropriate vendor file and may be updated on an annual basis.

In addition, the Facility will access any applicable state or federal database to determine whether a prospective vendor or professional provider has been excluded or otherwise found ineligible to participate in federal health care program, including the database operated by the General Services Administration containing a monthly listing of the debarred contractors. Internet accessible as follows:

US GSA	https://www.sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf
OIG	https://exclusions.oig.hhs.gov/
NY OMIG	http://www.emedny.ore/info/disqualified.html

VII. MONITORING AND AUDITING

A. **Internal Risk Assessment.** Under the direction of the Compliance Officer, the Facility will establish a system of internal reviews of each applicable department for the purpose of assessing the risk of non-compliance with governmental and third-party payor standards. Based on this risk assessment, the Compliance Officer and Compliance Committee will develop an internal work plan for the Facility on an annual basis and which will be reviewed quarterly by the Compliance Committee. The completion of the risk assessment will be done annually and will form the basis for an annual Work Plan which will be provided to the governing authority as part of the Compliance Committee's annual report.

B. **Internal Control Systems.** In those areas where the Compliance Committee has determined the need for internal control systems, the Compliance Officer, in conjunction with the appropriate department head, shall develop and establish internal control mechanisms designed to detect and prevent violations of legal and regulatory and ethical standards. Where internal control mechanisms and procedures are in place, the Compliance Officer, in conjunction with the appropriate department head, shall review such procedures to determine their effectiveness and revise such procedures if necessary. The Compliance Officer may engage outside consultants to assist in this process.

C. **Internal Auditing.** Periodically, but not less than twice per year, the Compliance Officer, or his or her designee, will conduct audits of those areas where internal control mechanisms and procedures have been required to determine compliance therewith. In particular, the Compliance Officer, in conjunction with appropriate Facility staff, shall develop both pre-submission and post-submission claim audit procedures.

Pre-submission claim audits may include, as applicable:

1. Random sampling of data which forms the basis for Medicaid and Medicare claims prior to submission;

2. Obtaining the physician's order for services reflected therein or other documentation or certificate of medical necessity;

3. Obtaining the care plan and medical records;

4. Comparing codes, diagnoses and procedures included within any claims or medical data sets with documentation provided in the clinical record;

5. Ensuring that all appropriate clinical documentation is available and documented to support the claim;

6. Ensuring that the medical necessity of services billed is appropriately documented in the care plan and medical record.

7. Assessing any metrics, goals and/or quality outcomes which may be required relating to value-based reimbursement arrangements or standards.

Post-submission review will involve:

1. Random sampling of data which forms the basis for claims submitted for billing over a specified period with regard to both Medicare and Medicaid;

2. Reviewing the claims with the medical record to ensure that all documentation necessary to support the claim is contained in the medical record and that the medical record establishes the medical necessity for the claimed services.

D. **External Audits.** The Compliance Officer shall arrange and coordinate with outside consultants for the external audit of those departments and areas involving compliance issues. External audits will be conducted periodically as scheduled by the Compliance Committee.

E. **Reports and Corrective Action.** The Compliance Officer shall provide the Compliance Committee with appropriate reports with regard to internal and external audits. In the event an internal or external audit discovers a violation of legal, regulatory or ethical standards, the report will recommend appropriate corrective action, including revision of internal control mechanisms and procedures, disciplinary action, submission of revised claims or billings, self-reporting and refunding of overpayments. The Compliance Officer will develop periodic reports on the ongoing monitoring of the compliance efforts as well as follow-up reports regarding identified risk areas. These reports will be maintained in the compliance files and shared with the Board, the Compliance Committee and appropriate CEOs.

F. **Self-Disclosure Policy.** The self disclosure of overpayments, violations and other matters affecting the Facility's participation in Medicaid, Medicare and other public health care programs will follow the published guidance issued by the Office of the Medicaid Inspector General, the Office of the Inspector General within the Federal Department of Health and Human Services and all other duly promulgated guidelines and regulations pertaining to such matters.

VIII. INVESTIGATION

The Compliance Officer, with assistance of the Compliance Committee, will investigate all reports of suspected violations of legal, regulatory and ethical standards. All reports of alleged violations of such standards received by supervisory personnel shall be immediately forwarded to the Compliance Officer. All reports of suspected violations of such standards received by the Compliance Officer shall be reported to the Compliance Committee. The Compliance Officer will investigate any report regardless of how it is made, anonymously or verbally and/or using other forms of media such as email, mail, voicemail Compliance Incident Reporting System, or social media, which may come to the attention of staff and form the basis of a report. The Compliance Officer will assure that all reports of suspected violations are discussed with the full Compliance Committee for action, referred for legal review or, if warranted, noted as unsubstantiated.

Recommended components of an investigation are as follows:

1. Interview of the individual filing the report, unless anonymously filed, as soon as possible after the report has been filed. Such interview shall be conducted in private and in as confidential a manner as possible. The individual should be encouraged to disclose all facts and other relevant information regarding the alleged violation and the individual should be encouraged to provide a written summary of his/her complaint. The individual should be reminded that Facility will not tolerate any form of intimidation, retaliation or retribution against the individual for making the complaint;

2. Interview of any witnesses or other individuals with knowledge regarding the reported suspected violation, including employees, vendors and other providers. Such interviews shall be conducted in private and in as confidential manner as possible. Such witnesses should be encouraged to provide all pertinent information and facts and encouraged to sign a statement summarizing. Witnesses should be reminded that Facility does not tolerate intimidation, retaliation or retribution against any individual who has participated in an investigation of a report of a suspected violation;

3. Assembly and review of all appropriate documentation;

4. Interview of any alleged wrongdoer. Such interview should be conducted in private and in an as confidential manner as possible. Explain to the alleged wrongdoer that a complaint has been made concerning a possible compliance violation and that no conclusions or decisions have been and will not be made until the matter has been fully investigated. Remind the alleged wrongdoer that failure to cooperate, untruthfulness or omission of pertinent information will result in disciplinary action. Remind the alleged wrongdoer that intimidation, retaliation or retribution against the individual filing the report of the suspected violation or any individual who has participated in the investigation will not be tolerated and will result in appropriate disciplinary action.

5. If necessary, internally perform or engage outside experts to conduct any required auditing functions required as part of the investigation.

Interviews of the alleged wrongdoer should be conducted with one other member of the Compliance Committee or appropriate member of the management team present. Notes taken during the interview should become part of the report/memorandum and filed with the complaint for further action. If appropriate, the person interviewed may provide a written statement as to any key facts which are revealed during this process. The identity of the alleged wrongdoer shall be maintained confidential at all steps of the process.

Upon the completion of the investigation, the Compliance Officer shall report to be the Compliance Committee detailing the substance of the alleged violation, the evidence discovered during the investigation, the Compliance Officer's findings and recommended corrective action. The Facility will follow appropriate Self Disclosure guidelines as set forth in the Self-Disclosure and/or as otherwise required by law based on the results of any particular investigation.

The Compliance Officer will review the investigation report with the Compliance Committee and recommend to administration the appropriate form of corrective action to be taken. The administration, with the assistance of the Compliance Officer and Compliance Committee, will implement appropriate corrective action.

At any time during an investigation, the Compliance Committee may engage legal counsel to conduct the investigation, if, in the opinion of the Compliance Committee, such action is warranted. If legal counsel is engaged to conduct the investigation, the Compliance Officer will assist counsel in such investigation. When outside legal counsel is engaged to conduct the investigation, counsel shall prepare a report to the Compliance Committee setting forth the substance of the alleged violation, the evidence and findings of the investigation and recommended corrective action.

IX. RESPONSE TO DETECTED OFFENSES

The Facility will correct compliance problems promptly and thoroughly, implementing procedures, policies and systems as necessary to reduce the potential for recurrence. The Compliance Officer shall initiate and supervise investigations into suspected misconduct. The Compliance Officer will take appropriate steps to secure the integrity of documents or other evidence relating to the investigation. Consultation with outside counsel and/or third-party consultants will be obtained as needed.

Individuals involved in the suspected misconduct may be reassigned or placed on a temporary leave, during the investigation, as appropriate. Interim measures will be taken in accordance with the individual's due process rights in accordance with applicable laws and regulations, and Facility rules.

The Facility will report any misconduct to the OIG or the OMIG, if such misconduct is subject to the duty to report. The Facility will have a system for routinely identifying and reporting necessary compliance issues to DOH and/or the OMIG and for making any financial adjustments as appropriate. Credit balances resulting from overpayments identified during a compliance investigation are funds that the Facility has an obligation to return to the appropriate agency, carrier or intermediary unless offsets can be made in the process of audit adjustments or settlement claims with consent of the relevant governmental agency. The Facility will also have a system in place for refunding overpayments as appropriate and adherence to the Facility's Self Disclosure Policy.