CORPORATE COMPLIANCE PLAN

ONEIDA MEDICAL PRACTICE, P.C.
&
ONEIDA MEDICAL SERVICES, PLLC

AFFILIATES OF
ONEIDA HEALTH HOSPITAL

March 2013
Reviewed Dec 2014

Revised Feb 2017
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Reviewed June, 2024
Reviewed June, 2025
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Dear Board Members, Fellow Employees, Associates and other Workforce Members:

Oneida Health Hospital, including its divisions listed under Schedule 1 of this Corporate Compliance Plan, is subject to a wide variety of legal, regulatory and professional requirements with which we all must comply. This Corporate Compliance Plan describes Oneida Health Hospital's mandatory Corporate Compliance Program. Because these requirements can be complicated, this plan was designed to help all persons affected by Oneida Health Hospital's risk areas, including employees, the chief executive officer of Oneida Health Hospital and other senior administrators, managers, and contractors, agents, subcontractors and independent contractors (collectively "Contractors"), and governing body and corporate officers ("Affected Persons") of Oneida Health Hospital, including the hospital and all its departments and health centers, the Extended Health Care Facility, Oneida Health Hospital's affiliated physician practices, and any other department or entity which is part of Oneida Health Hospital, as appropriate, understand them. This plan will assist each of us in making appropriate decisions when we are faced with compliance issues. Key elements of this plan include a Code of Conduct and information on how the Corporate Compliance Program is structured, including defined channels of communication (e.g., a confidential hotline) for addressing your questions or concerns.

As described in this plan, Oneida Health Hospital's Corporate Compliance Program has been developed to explain corporate compliance at Oneida Health Hospital, as well as its acute care facility, extended care facility and Article 28 Health Centers. This plan complies with the compliance program requirements found under Social Services Law § 363-d and 18 NYCRR Subpart 521-1, and incorporates recommendations enumerated in the Department of Health and Human Services, Office of Inspector General Compliance Program Guidance for Hospitals and the Federal Sentencing Guidelines for Organizations, effective compliance program and ethics guidance. In addition, this plan describes how the Corporate Compliance Program overlaps with Oneida Health Hospital's affiliates, including Oneida Medical Practice, P.C. ("OMP"), Oneida Medical Services, PLLC ("OMS"), (Oneida Health Hospital, together with its divisions and affiliates, as applicable, are collectively referred to in the plan as "Oneida Health Hospital" or "OHH"). This Corporate Compliance Plan is grounded in OHH's mission statement that governs how we conduct business. Our Board of Trustees and Senior Management Team are committed to following and communicating this Corporate Compliance Plan to all levels of our organization.

In this changing and challenging era for health care, the public's trust, confidence and respect for our organization requires the commitment of each of us to uphold standards of excellence and ethical behavior. The anti-fraud, waste and abuse efforts of the Department of Health and Human Services (DHHS), Office of Inspector General (OIG), Department of Justice (DOJ) and Office of the Medicaid Inspector General (OMIG) have heightened over the recent years, partially due to the threat of future Medicare insolvency. The OIG, DOJ and other governmental agencies have been investigating health care providers nationwide for non-compliance with laws and regulations at an ever-increasing rate.

Now more than ever, we believe it is important to reaffirm Oneida Health Hospital's longstanding commitment to conduct all work and business affairs lawfully and with integrity. We want to ensure that there continues to be no basis for charges of non-compliance with laws and regulations against our organization, our employees, medical staff members or those that we conduct business with.

This plan should be considered a "living document" that will be updated routinely. It will change and expand as policies are revised and as new resources become available. This plan is for you and only with input and feedback from you can we make it useful and responsive to your needs. The most current plan will be available on the policy and procedure section of the Intranet, on our external website, and through the Office of the Compliance Officer.

Please read through the plan and contact either myself or the Corporate Compliance Officer with any questions or concerns you may have. Thank you for all you do, each and every day, for our patients/residents and for each other.

Sincerely,

Felissa Koernig, JD/MBA, FACHE
Chief Executive Officer

Under Health Reform Law and as a condition of enrollment in Medicare and Medicaid, providers must establish a compliance program. A compliance program is a proactive and reactive system of internal controls, operating procedures and organizational policies to ensure that the rules that apply to the provider are regularly followed.

This Corporate Compliance Plan has been established in conjunction with the Corporate Compliance Program and Corporate Compliance Plan applicable to individuals affiliated with Oneida Health Hospital. Those documents, which are hereby incorporated by reference, are applicable to Oneida Medical Practice, P.C. and Oneida Medical Services, P.L.L.C., including the divisions listed under Schedule 1 of this Corporate Compliance Plan, and describe the compliance obligations for all persons affected by Oneida Health Hospital's risk areas, including employees, the chief executive officer of Oneida Health Hospital and other senior administrators, managers, and contractors, agents, subcontractors and independent contractors, and governing body and corporate officers ("Affected Persons") of Oneida Health Hospital, including the Practices (as defined herein), as appropriate.

I. ELEMENTS OF A CORPORATE COMPLIANCE PROGRAM

New York State Social Services Law 363-d recognizes that compliance programs should reflect a provider's size, complexity, resources and culture. However, the statute requires that all compliance programs satisfy the mandatory elements set out in 363-d subdivision 2 and 18 NYCRR Sub-Part 521-1. The specific required elements of a corporate compliance program have been issued by the health care branches of the Federal government, the Office of Inspector General (OIG), the State government, and the Office of Medicaid Inspector General (OMIG), who are charged with detecting, monitoring and preventing health care fraud and abuse.

The required elements include:

- Written standards of conduct, policies and procedures;
- Designating a Compliance Officer and a Compliance Committee;
- Training and education;
- Lines of communication;
- Responding to compliance issues;
- Auditing and monitoring; and
- Disciplinary standards.

II. COMMITMENT STATEMENT

Oneida Health Hospital and its affiliated entities, including its group physician practices, Oneida Medical Practice, P.C. ("OMP") and Oneida Medical Services, P.L.L.C. ("OMS") (collectively "Oneida Health Hospital" or "OHH"), have demonstrated a commitment to compliance by adopting these elements of a corporate compliance program through the following actions:

- Development of this Corporate Compliance Plan for OMP an OMS (collectively the "Practices"), which operates in conjunction with the Corporate Compliance Plan for the Oneida Health Hospital system. This Corporate Compliance Plan includes designation of Corporate Compliance Liaisons responsible for the day-to-day operation of the compliance program for the Practices who will report to Oneida Health Hospital's Corporate Compliance Officer, and the respective governing board of the Practices. The Board of Trustees (the "Board") for OHH is the governing body over the OHH Corporate Compliance Program and also oversees the compliance program for OMP and OMS.

- The Corporate Compliance Liaisons also serve as members of Oneida Health Hospital's Corporate Compliance Committee, which operates in accordance with the OHH Corporate Compliance Committee Charter attached hereto as Schedule 2. The Board receives the monthly Corporate Compliance Committee minutes and quarterly reports presented by OHH's Corporate Compliance Officer. This designation is critical to ensuring that the Compliance Program remains visible, active, effective and accountable.

- Development and distribution of a written code of conduct, as well as specific Compliance Program-related policies and procedures that promote OHH's commitment to compliance and provide guidance and expectations for all Affected Persons. All policies are posted on Oneida Health Hospital's intranet for easy accessibility.

- Development and implementation of effective compliance-related training and education programs as set forth in more detail in this plan. OHH employ a customized electronic training system, Inservice Solutions, which tracks completion of employees' required compliance training annually. All Affected Persons attend or review a general orientation session or receive one-on-one training with the Corporate Compliance Officer covering compliance issues, expectations and the operation of the Compliance Program, EMTALA and privacy related topics. Additional specialized compliance training is conducted for specific employees and/or departments that are deemed as having higher risk operations, such as the coding and billing functions. Training and education provides all OHH employees, including the Corporate Compliance Officer and Corporate Compliance Liaisons, the Chief Executive Officer and other senior administrators, managers and members of the Board, with an understanding of our compliance programs, legal requirements applicable to OHH and knowledge of our compliance-related policies and procedures. Compliance education and training is also part of orientation for new employees, and newly appointed compliance officers and Affected Persons, including a chief executive, manager and board member. Orientation and annual training creates an opportunity to convey our organization's commitment to ethical and legal conduct and remind staff of their role in compliance. Contractors receive specific privacy and compliance education programs developed by the Corporate Compliance Officer. For Contractors that are also required to maintain an effective compliance program, the Corporate Compliance Officer will consider the most efficient manner in which to provide compliance training, including any training provided directly by the Contractor. OHH providers receive annual compliance training at the semi-annual Medical Staff meeting, as well as in individual meetings at their offices with the Corporate Compliance Officer.

- Implementation of a 'reporting and response mechanism' to answer questions and receive reports of actual and potential non-compliance or concerns and a procedure for the Corporate Compliance Officer or Corporate Compliance Liaisons to address them, including a report form, an anonymous hotline and open lines of communication via email, phone or face-to-face meetings with the Corporate Compliance Officer. To facilitate prevention, detection and corrections of actual or potential non-compliant conduct, it is necessary for all individuals affiliated with OHH, including all Medicaid recipients of services from OHH, to feel comfortable in reporting compliance issues. It is critical that OHH maintain open lines of communication and an environment is created whereby Affected Persons do not have reason to fear intimidation or retaliation for reporting. Accordingly, a policy of non-intimidation and non-retaliation for good

faith participation and reporting has been implemented to create a culture where fear is not a deterrent to reporting concerns.

- Implementation of a process to respond to any allegations of potential non-compliance as they are raised, whether intentional or not. For OHH's Compliance Program to be effective, we must ensure that Oneida Health Hospital has taken steps to correct any potential or actual occurrences of non-compliance, including non-compliance with Medicare and Medicaid requirements and New York and federal fraud, waste and abuse rules. An in-depth investigation occurs for each credible allegation or concern reported or identified to determine the extent, causes and seriousness of the situation. Best efforts are used to ensure the non-compliant conduct is halted immediately and the effects of the non-compliant conduct are mitigated. OHH's corrective actions take aim at reducing the likelihood of similar instances or reoccurrence in the future.

- Use of routine monitoring activities and conducting internal and external audits and self-evaluations to determine the rate of compliance with specific regulations and to decrease the risk of non-compliance, including New York and federal fraud, waste and abuse rules and Medicaid and Medicare requirements, and in determining the overall effectiveness of the Compliance Program. These risk areas tend to change over time as the Federal and State governments change focus and as internal computer applications and processes change. Additionally, OHH does cooperate and glean insight from external audits conducted by a variety of agencies. The Practices develop an annual Work Plan outlining particular areas of risk and opportunity for those entities, in addition to the yearly compliance Work Plan instituted by OHH.

- Implementation of a process that verifies that Oneida Health Hospital, including the Practices, has not employed or contracted with Affected Persons that are listed on the OIG or OMIG exclusion websites as excluded providers from the Federal and State health care programs. This means neither OHH nor the Practices may receive reimbursement from Medicare or Medicaid for services provided by an Affected Person if they are listed as OIG or OMIG excluded and generally cannot do business with them. This is not only a monthly submission process for OHH but also one that is used daily, including when new ordering physicians enter OHH's health system.

- Following *Human Resources Disciplinary Policy HR 11* and *Progressive Disciplinary and Sanction Policy CC 16-30* for Affected Persons of OHH when it has been determined that compliance policies, regulations, Federal or State Health Care Program requirements have been violated. Examples of violations include failing to report suspected problems, participating in or facilitating non-compliant behavior or refusing to do so, and encouraging or directing active or passive non-compliant behavior. Enforcing disciplinary standards is important not only to give the Corporate Compliance Program credibility, but also to demonstrate OHH's integrity and commitment to compliance and desire to prevent recurrence and ensure effectiveness. With respect to governing board members, disciplinary actions will be taken in accordance with the applicable bylaws of the entity. In addition, agreements with Contractors[1] will include the right to terminate the agreement in the event the Contractor fails to comply with OHH's Compliance Program as it relates to the risk areas potentially affected by the Contractor.

[1] Consistent with 18 NYCRR § 521-1.3(c), "Contractors" as sometimes used herein collectively refers to contractors, agents, subcontractors, and independent contractors of the Practices unless otherwise noted.

- Creation and implementation of a process to refund any overpayments that Oneida Health Hospital or the Practices discover may have been received inadvertently from Medicare, Medicaid or third-party payer. The Practices have a refund tracking process that is monitored by Strategic Solutions, a third party billing vendor. . *Please refer to Response to Overpayments Policy CC 16-23*.

These commitment statements follow the recommended structure for the seven[2] elements of a corporate compliance program as promulgated by the OIG Compliance Program Guidance and from Title 18 of the Codes, Rules and Regulations of the State of NY, Sub-Part 521-1 effective December 28, 2022.

III. WRITTEN POLICIES AND PROCEDURES AND CODE OF CONDUCT

The OHH Code of Conduct serves as the foundation for the Practices' compliance, privacy, customer service, and patient safety programs. It reflects the behaviors consistent with laws and regulations and with our commitment to caring. OHH's policies and procedures and the Code of Conduct are reviewed annually to determine whether they have been implemented throughout the organization and are being followed, as well as for their effectiveness, to determine if any updates are required. These policies and procedures and the Code of Conduct establish the expectation of ethical behavior and compliant conduct and describe the responsibilities of all Affected Persons in carrying out the functions of the Compliance Program, including OHH's policy for taking disciplinary action for failure to adhere. *Please refer to OHH's Administrative Policy HR 068 "Code of Conduct and Disruptive Behavior"* and *CC 16-45 "Corporate Compliance Code of Conduct."*

The Code of Conduct applies to all Affected Persons. The following is a general overall guide to ethical behavior:

1. Oneida Health Hospital promotes **respect** for patients as well as employees, agents, physicians, volunteers and visitors.

2. Oneida Health Hospital actively fosters **teamwork, communication and collaborative work environment** among members of the patient care team, customer service support team and among groups that meet for the purpose of improving health status including but not limited to trustee, physician and manager groups.

3. Oneida Health Hospital encourages **honesty and integrity** in communication and fair evaluation of programs and persons. This behavior is reflected in our marketing, admissions, purchasing, transfer, discharge and billing procedures. It also guides the organization, employees and agents in their relationships and interactions with other health providers, educational institutions, vendors and payors.

4. Oneida Health Hospital **does not discriminate** in its business and corporate practices. The organization follows all Federal and state anti-discrimination laws that apply to the admission/discharge process and to the purchase of services and supplies.

[2] While the new regulations provide for eight elements, OMIG guidance notably combines the discussion of the compliance officer and compliance committee into one element (see 18 NYCRR § 521-1; OMIG Compliance Program Guidance, January 2023 (https://omig.ny.gov/compliance/compliance-library)).

5. Oneida Health Hospital's **vision, mission, and values** guide the planning and business practices and patient care experience.

6. Items and services are provided to customers in a manner that respects and fosters their sense of **dignity, autonomy, and positive self-regard, civil rights and involvement in their own care**.

7. All staff, physicians and volunteers will exhibit a **Commitment to Patient Centered Care and to Co-workers** to establish a culture of **patient safety and teamwork**.

IV. COMPLIANCE OVERSIGHT STRUCTURE

The compliance oversight structure at Oneida Health Hospital consists of the following compliance-related roles:

- OHH Corporate Compliance Officer ("Corporate Compliance Officer");
- Corporate Compliance Liaisons for the Practices and Article 28 Health Centers;
- OHH Corporate Compliance Committee ("Corporate Compliance Committee"); and
- The Board of Trustees and President/CEO of Oneida Health Hospital are ultimately in charge of governance of the Corporate Compliance Plans of OHH and the Practices[3].

These compliance related positions oversee not only functions at the hospital, but also the Corporate Compliance Plan for the Practices. In addition to the compliance-related roles, the Practices have named Corporate Compliance Liaisons, who are responsible for the day-to-day oversight of this Corporate Compliance Plan.

The Corporate Compliance Liaisons ensure appropriate oversight and monitoring of the adoption, implementation, maintenance and effectiveness of this Corporate Compliance Plan, in collaboration with the OHH compliance oversight structure, and will report any reported non-compliance or potential issues to the respective Presidents of the Practices, as well as the Corporate Compliance Officer.

The Corporate Compliance Liaisons of the Practices also serve as members of the Corporate Compliance Committee. These individuals work collaboratively with the Corporate Compliance Officer to complete the designated corporate compliance responsibilities.

V. THE CORPORATE COMPLIANCE LIAISONS' RESPONSIBILITIES

- Responsible for day-to-day oversight of the Practices' Corporate Compliance Plan.
- Report directly and on a regular basis, but not less than quarterly to the MPN President and to the Corporate Compliance Officer regarding operation of this Corporate Compliance Plan and any issues of, or potential for, non-compliance.
- Maintain documentation related to the Corporate Compliance Plan, including but not limited to, compliance-related matters for the Practices within the minutes of the Corporate Compliance Committee meetings, compliance complaints and investigations, as well as the resolution of any complaint investigations.

[3] The governing board and officers for Oneida Medical Practice, P.C., Oneida Medical Services, PLLC and Genesee Physician Practice, PLLC also oversee the compliance plans for those entities, as described herein.

- Meet with personnel of the Practices to discuss any concerns about potential non-compliance.
- Assist Corporate Compliance Officer with follow-up for any compliance reports made, including document reviews, claims review, policy review and staff interviews.
- Report to the Corporate Compliance Officer, the Corporate Compliance Committee, and the President of the MPN and the Board of OHH.
- Serve as members of the Corporate Compliance Committee.
- Ensure any overpayments received are properly and timely refunded.
- Perform internal audits of areas designated by the Practice Work Plan and other areas as identified throughout the year.
- Assist Corporate Compliance Officer with appointing additional staff to assist in the performance of internal and external compliance reviews and audits, as deemed necessary.
- Provide a quarterly report to the Corporate Compliance Officer, the President of the MPN and the OHH Board of Trustees regarding topics investigated or internal audits conducted.
- Create and revise the Practice Work Plan on an annual basis.
- Maintain the privacy of protected health information.

VI. REPORTING & RESPONSE SYSTEM - WHERE TO GO FOR ASSISTANCE

As provided under Section IV of OHH's Corporate Compliance Plan, the Affected Persons of the Practices and others, including Medicaid recipients of services from OHH, have a variety of methods they may use to ask compliance-related questions or report potential compliance issues as they are identified. This includes a method for anonymous and confidential good faith reporting.

The following methods are available:

- Discuss the question or concern with the Practices' Corporate Compliance Liaisons, a member of the Corporate Compliance Committee or your direct supervisor (who in turn can seek assistance from the Corporate Compliance Officer, if necessary).
- Call the Corporate Compliance Officer directly at extension 2117 or phone 315-361-2117.
- Call the OHH Corporate Compliance Hotline at extension 2116 or phone 315-361-2116 where details can be left on voicemail anonymously and/or confidentially. Only the Corporate Compliance Officer has access to retrieve these calls and it is password-protected.
- Complete the Compliance Reporting Form (Form #01209) and submit the completed form directly to the Corporate Compliance Officer (by inter-office mail, regular mail or in person).*
- Email the Corporate Compliance Officer at rolmsted@oneidahealthcare.org

*The Compliance Reporting Form can be found (1) outside of the ACF Human Resources office, (2) in the ECF hallway near the nursing offices, and (3) on the OHH Intranet. In addition, the report form is located on Oneida Health Hospital's external website to provide non-employees with greater accessibility to report potential issues of non-compliance to the Corporate Compliance Officer at https://www.oneidahealth.org/wp-content/uploads/Compliance-Reporting-Form-01209-1.pdf

When making a report to the Corporate Compliance Hotline or completing a Compliance Reporting form (a copy of which is also attached to this Corporate Compliance Plan), individuals shall remain anonymous. If you desire, you can identify yourself to the Corporate Compliance Officer at the time you make the report which will assist the Corporate Compliance Officer in responding. All

reports submitted will be kept confidential, including reports made via the confidential method, unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or such disclosure is required during a legal proceeding or otherwise required by law.

Please refer to the OHH Compliance Reporting System Policy (CC 16-1) which is hereby adopted and incorporated by reference as applicable to the Practices.

VII. WHAT TO EXPECT WHEN YOU MAKE A COMPLIANCE REPORT – RESPONSE SYSTEM

Where issues of non-compliance are identified by, or reported to a Corporate Compliance Liaison, he/she will contact the Corporate Compliance Officer to initiate a response to all reports made within a reasonable time frame. Reports will not be responded to on a first-come, first-served basis, but rather by the nature and extent of potential non-compliance. If necessary, the Corporate Compliance Officer will seek advice from external legal counsel based on the severity of allegations and will report to the NYS Department of Health or OMIG as necessary.

In cases where the reporter is known, he or she will be notified in writing of the outcome of their report, to the extent deemed appropriate, by the Corporate Compliance Officer.

If it is determined that **criminal** misconduct has occurred, the matter will immediately be referred to external legal counsel to initiate contact with the appropriate law enforcement agency. Oneida Health Hospital is committed to returning any overpayment obtained in error from a Federal and State Health Care Program or other third-party payer in the event a compliance issue relates to billing errors or other non-compliance.

The Corporate Compliance Officer, with assistance from the Practices' Corporate Compliance Liaisons, is responsible for evaluating the training and education needs of the Practices and for conducting ongoing monitoring and auditing activities to prevent the reoccurrence of any incidents of non-compliance.

VIII. NON-INTIMIDATION AND NON-RETALIATION

As provided in Section VI of OHH's Corporate Compliance Plan, it is every Affected Person's responsibility to promptly raise questions or report concerns to ensure the effectiveness of these integrated Corporate Compliance Plans. **The Practices will not tolerate retribution, intimidation or retaliation (or in the case of employees, no adverse employment consequence or threat of an adverse employment consequence) against any individual who reasonably believes and who, in good faith,** raises a question or reports a perceived concern, including but not limited to, reporting potential issues, investigating issues, self-evaluations, audits and remedial action, and reporting to appropriate officials as provided in New York State Labor Law Sections 740 and 741. The Practices require each person's assistance to identify and report any suspicious behaviors or business practices to ensure the opportunity to investigate and correct them when necessary.

IX. COMPLIANCE TRAINING & EDUCATION POLICY

Affected Persons of the Practices will receive initial compliance training as directed under OHH's Corporate Compliance Plan at the time of new hire orientation and annually thereafter. This training shall, at minimum, cover the following required topics:

a. OHH's and the Practices' risk areas and organizational experience;

b. OHH's and the Practices' written policies and procedures (as applicable) as set forth in 18 NYCRR § 521-1.4(d)(1);

c. The role of the Corporate Compliance Officer, Corporate Compliance Liaisons and Corporate Compliance Committee;

d. How Affected Persons can ask questions and report potential compliance-related issues to the Corporate Compliance Officer, Corporate Compliance Liaisons, and members of the Compliance Committee, as well as other members of senior management, as appropriate, including the obligation of Affected Persons to report suspected illegal or improper conduct and the procedures for submitting such reports; and the protection from intimidation and retaliation for good faith participation in the Compliance Program;

e. Disciplinary standards, with an emphasis on those standards related to OHH's Compliance Program and prevention of fraud, waste and abuse;

f. How OHH responds to compliance issues and implement corrective action plans;

g. Requirements specific to the Medicaid program and the Practices' categories of service;

h. Coding and billing requirements and best practices, as applicable; and

i. Claim development and the submission process, as applicable.

Initial compliance training for all new employees, and newly appointed corporate compliance liaisons and Affected Persons, including a chief executive, manager, and board member, is incorporated into the general orientation process or received via a one-on-one training session with the Corporate Compliance Officer, which includes the required topics set forth above and compliance issues, expectations and the operation of OHH's Compliance Program. Individuals who attend general orientation may complete a written quiz and score 80% or above to receive credit for this training. In addition, Affected Persons are required to sign an acknowledgement of receipt of the Corporate Compliance Plan and to have knowledge of where and how to access OHH's corporate compliance policies and procedures.

Continued compliance education and training is provided on an annual basis thereafter, and includes education on New York and federal False Claims Acts and whistleblower protections, as well as the required topics. Mandatory annual training for all employees is provided online through 'Inservice Solutions'. The Corporate Compliance Officer, the Chief Executive Officer, and other senior administrators, including the President of the MPN, managers and members of the OHH Board are required to attend annual compliance training. Specialized compliance training is also provided on an annual basis to board members.

Specialized training is also provided to Contractors who receive specific privacy and compliance education programs on a periodic basis, and will be screened through a vendor credentialing service. For Contractors that are also required to maintain an effective compliance program, the Compliance Officer will consider the most efficient manner in which to provide compliance

training, including any training provided directly by the Contractor. Additional privacy and compliance information targeted for these groups is provided in the non-employee handbook.

Periodic compliance training and education sessions are developed and scheduled by the Corporate Compliance Officer to provide all providers and non-medical staff of the Practices with information on compliance issues, expectations and the operation of the Corporate Compliance Program.

Compliance training and education will be given using a method that is accessible and understandable by the individuals required to receive training. Attendance and participation in these education programs is a condition of continued employment or affiliation with OHH. Attendance is tracked and enforced. Failure to meet minimum prescribed requirements will result in disciplinary action, including possible termination by or affiliation with OHH.

OHH also utilizes a training plan which outlines the scope of its training and education program, including the topics to be discussed; the timing and frequency of training; the Affected Persons subject to attendance and how attendance will be tracked; and the periodic evaluation of the effectiveness of the training.

The Practices hereby adopt and incorporate by reference OHH's Compliance Training and Education Policy (CC 16-7), which provides additional information. Please also refer to Oneida Health's Training Plan.

X. MEDICAID COMPLIANCE PROGRAM (OMIG)

The NYS Office of the Medicaid Inspector General ("OMIG") requires providers to have an effective compliance program that addresses, at a minimum, the following items:

A. 18 NYCRR 521-1.3(d)(1): Billings
   1. Internal controls for documentation during data entry and billing.
   2. Billing office internal audit results shared with compliance.
   3. Conduct root cause analysis for persistent billing denials.
   4. Conduct tracer audits for work being billed.
   5. Self-assess if number and value of adjustments is accurate.
   6. Separation of duties in billing and receipt functions.
   7. Involvement of CO in analysis of strengths and weaknesses.

B. 18 NYCRR 521-1.3(d)(2): Payments
   1. Track and analyze any overpayments, underpayments, and denials.
   2. Results of accounts receivable internal audits are shared with CO.
   3. Conduct tracer audit for payments to assess accuracy of billing and resulting payments.
   4. Determine if billing and payment system weaknesses are being identified and corrected as necessary.
   5. Involvement of CO in analysis of strengths and weaknesses.

C. 18 NYCRR 521-1.3(d)(3): Ordered Services
   1. Develop compliance connectivity to quality oversight process for services ordered for the Practices' patients.
   2. Determine if the billing and payment system accurately and effectively capture ordered services.
   3. Involvement of CO in the analysis of strengths and weaknesses.

D. 18 NYCRR 521-1.3(d)(4), (5): Medical necessity and quality of care

1. Develop compliance connectivity to quality oversight process as part of the reporting and control structures.
2. Conduct periodic tracers of care to assess if quality requirements are being met and provide reports to the compliance function.
3. Develop quality scorecards with resolution of outliers being reported to the compliance function.
4. Review documentation for completeness and appropriateness of entries.
5. Tracking and resolution of complaints from clients, patients, and family members.
6. Reporting of statistics and responses to aberrations of medical necessity and quality issues to the CO to be used for a control test for the effectiveness of the underlying control process.

E. 18 NYCRR 521-1.3(d)(6): Governance

1. Meaningful conflict of interest policy for Governing Body and management with reporting of unresolved conflicts.
2. Compliance function is connected to all management and Governing Body entities within the enterprise.
3. Include the Governing Body in compliance plan approval process and in setting compliance budget.
4. Include Governing Body in self-assessment and work plan process to include planning, tracking progress, and budgeting.
5. Governing Body oversight of the compliance program.
6. Frequency of compliance reports to the Governing Body.
7. Compliance training of the Governing Body and management.

F. 18 NYCRR 521-1.3(d)(7): Mandatory reporting

1. Report, repay, and explain all overpayments.
2. Required reporting of compliance issues for all Affected Persons.
3. Required reporting of compliance issues to DOH and OMIG. Testing periodically on completeness of mandatory reporting of billing, payment, quality, and contractual issues.
4. Quality control of reporting to ensure accuracy and completeness of reports being made.
5. Ensure compliance with applicable mandatory reporting obligations: a. annual SSL certification; b. annual DRA certification; c. SADC certification; and/or d. other regulatory and program reporting.

G. 18 NYCRR 521-1.3(d)(8): Credentialing

1. Regularly check accuracy and comprehensiveness of credentialing process. A. Identify Affected Persons who must be credentialed. B. Include normal credentialing considerations like primary source verification and licenses.
2. Regularly check the excluded party lists and take appropriate action if Affected Persons are on those lists. OMIG requires monthly checks of the excluded party lists.

H. 18 NYCRR 521-1.3(d)(9): Contractor, Subcontractor, Agent or Independent Contract Oversight

1. Determine the areas of greatest risk for violation of the Practices' Corporate Compliance Plan for each contractor, subcontractor, agent or independent contractor based on the services provided by the entity.
2. Prepare training and education programs specific to the contractor, subcontractor, agent or independent contractor that apply to the risk areas of non-compliance.
3. Communicate the expectations and requirements for the contractor, subcontractor, agent or independent contractor to comply with the Practices' Corporate Compliance Plan.

I. 18 NYCRR 521-1.3(d)(10): Other risk areas that are or should with due diligence be identified by the provider through its organizational experience.

1. Determine if your compliance program is covering all risk areas specific to your provider type. BOC recommends Periodic and routine self-assessments and gap analyses because at any particular point in time, risks may change.
2. Assess affiliates' program integrity. Commitments that affiliates (non-employees) are making to the Required Provider will require some level of audit and investigative expertise and activity.
3. Stratify risks within the compliance program. BOC recommends that Required Providers rank risk areas based upon frequency, severity, impact, etc. and address the ones that create the most exposure.
4. Expand risk areas based upon compliance program history and its operations. As compliance issues are identified and resolved, they should be considered risks to be addressed in the future or the resolution tested to be sure that it resolved the problem needing attention. The analysis should include the other six areas discussed above.
5. For associates (non-employees) that provide Medicaid reimbursable services through the Required Provider, determine if they are independently required to have a compliance program and if they have met the annual certification obligation.
6. Monitor compliance with annual certification obligation for associates, if any.

These areas are incorporated into the applicable sections of this Corporate Compliance Plan, as well as the Corporate Compliance Plan for OHH, and its policies and procedures. The Practices will perform a yearly self-assessment of the effectiveness of its Corporate Compliance Plan using the tools made available on the OMIG website.

The Practices hereby adopt, as applicable, and incorporate by reference the following OHH policies that address these topics listed below:

- ***CC 16-9 – Billing and Claims Submission Policy***
- ***CC 16-23 – OHH's Response to Overpayments***
- ***CC 16-27 – Governance for the Corporate Compliance Program***
- ***CC 16-28 – Monitoring of Medical Staff Credentialing & Annual Internal Audit***

XI. MEDICAID COMPLIANCE PROGRAM CERTIFICATION

Pursuant to New York State Social Services Law (SSL) § 363-d, providers are required to certify to the NYS Department of Health (DOH) upon enrollment in the Medicaid program and on an annual basis thereafter that the provider is satisfactorily meeting the requirements of SSL § 363-d through the *Certification of Statement for Provider Billing Medicaid* form. Through its submission of the certification, the Practices, as appropriate, are attesting that they are satisfactorily meeting the requirements of SSL § 363-d, which includes the federal Deficit Reduction (DRA) certification.

XII. MEDICARE COMPLIANCE PROGRAM (OIG)

The Office of Inspector General (OIG) is in charge of administering the integrity of the Medicare program. The OIG has numerous Compliance Program Guidance documents covering a variety of healthcare industry segments. Each Guidance Document outlines the seven elements of a compliance program (as referenced in our Commitment Statement in Section II, above). The OIG issues updates to its Work Plan website monthly revealing those designated high-risk areas that have potential for healthcare fraud and abuse. To that end, the Practices will use the guidance documents and OIG web-based Work Plan and updates to assist in its quest to decrease the instances of healthcare fraud and abuse, including regular review of updates to the web-based OIG Work Plan to determine which items may pose a medium to high risk to the Practices. The Practices' Corporate Compliance Liaisons will work with the Corporate Compliance Officer and Corporate Compliance Committee to include those focus areas in the yearly Practice Work Plan.

There are six OIG Compliance Program Documents that are applicable to the Practices' scope of business that provide detailed examples of the compliance risks with the operations for each service line:

- Hospitals;
- Supplemental Guidance for Hospitals;
- Clinical Laboratories;
- Individual and Small Group Physician Practices;
- Nursing Facilities; and
- Supplemental Guidance to Skilled Nursing Facilities.

All Affected Persons should be aware of the risk areas identified, as well as the Practice Work Plan, and should bring any potential instance of non-compliance or concern to the attention of the Corporate Compliance Liaisons or the OHH Corporate Compliance Officer using one of the many methods of reporting described above.

The specific Guidance Documents and additional information can be found at: http://oig.hhs.gov

XIII. WHAT DOES COMPLIANCE MEAN TO ME?

There are complex and frequently changing rules and regulations that guide each particular type of service line that OHH follows to help ensure compliant behavior. Therefore, it is not possible to list every potential compliance related scenario. If you are facing a situation where you think there might be a compliance related issue, please use one of the provided methods of reporting. Each Affected Person remains responsible and accountable for his/her compliance with applicable laws that govern his/her position and job responsibilities.

The information below is meant to provide examples, not meant to be exclusive, of specific compliance guidelines for the medical staff and employees at the Practices. These examples describe the broad nature of OHH's Corporate Compliance Program and how they impact day-to-day activities with not only services provided, but also business functions[4].

- Reporting of any potential Corporate Compliance or Privacy concern.
- Ensuring accuracy of registration information by verifying **all** patient information including insurance at each encounter.
- Ensuring patient completes a general consent for treatment which includes authorization to bill insurance and authorization to release information. (Assignment of Benefits)
- Making an effort to collect all co-payments and deductibles due from patients.
- Ensuring patients show proof of their identity.
- Utilizing advance beneficiary notices ("ABNs"), when applicable.
- Ensuring the selection and accuracy of any codes applied.
- Ensuring complete medical record documentation is obtained.
- Accurate charge and credit processing.
- Ensuring the super bill is revised every year.
- Exhibiting behavior that is consistent with the code of conduct.
- Maintaining the privacy of protected health information.
- Ensuring OHH's privacy practice policy is followed if disclosure of protected health information is necessary.
- Maintaining familiarity with the work plan for the applicable group.

XIV. DISCIPLINARY ACTIONS & SANCTIONS

The Practices hereby adopt and incorporate by reference OHH's *Human Resources Disciplinary Policy HR 11* and *Progressive Disciplinary and Sanction Policy for Compliance Program CC 16-30 (copies of which can be found on the OHH website)*. After an investigation, if the concern reported requires disciplinary action, the disciplinary process will proceed as outlined in the aforesaid *Policies HR 11* and *CC 16-30*.

All Affected Persons must refuse to participate in unethical or illegal conduct, report unethical or illegal conduct, including potential issues of non-compliance, and are expected to assist in the investigation and resolution of compliance issues. Therefore, it is expected that all Affected Persons will report compliance issues according to the policies and procedures described in this Corporate Compliance Plan. Failure to report compliance issues of which an Affected Person is aware will result in such individual being subject to discipline. OHH's disciplinary policies establish the degrees of disciplinary actions and describe sanctions that will be taken for (1) failing to report suspected problems, (2) participating in (or refusing to participate in) or facilitating illegal, unethical or non-compliant behavior, and (3) encouraging, directing, facilitating or permitting active or passive non-compliant behavior.

Sanctions, which are penalties imposed, may include oral or written warnings and can result in not only disciplinary action, but also the removal of certain employment privileges, contract penalties, suspension and discharge from employment and, in some cases, civil and/or criminal prosecution from a government agency against an employee or medical staff member. As this is not an all-inclusive list, senior management may need to be involved in recommending any sanctions imposed for non-employees.

[4] Additional examples may also be found in OHH's Corporate Compliance Plan, which is available on OHH's intranet, external website, or through the Office of the Corporate Compliance Officer.

Affected Persons may also be subject to disciplinary action for:

- Failure to participate in required compliance education and training and failure to complete any assigned compliance assignments.
- Failure of management personnel to detect non-compliance where reasonable due diligence on their part would have led to the discovery of such non-compliance.

It is important to note that depending on the severity of the non-compliant behavior, progressive discipline may not be required, and immediate discharge is possible. Disciplinary policies will be enforced fairly and firmly, and they will apply equally to all Affected Persons.

XV. WHAT TO DO IN CASE OF AN ON-SITE GOVERNMENT INVESTIGATION OR SEARCH WARRANT

While it is very unlikely, an on-site government fraud and abuse investigation could occur at the Practices. Oneida Health Hospital is committed to preparing all Affected Persons in the unlikely event it should happen.

An investigation could be commenced during any time of the day, evening or night. Government officials could be from a number of government agencies, including, but not limited to, the OIG, Department of Justice (DOJ), Federal Bureau of Investigations (FBI), United States Attorney's Office, the Fiscal Intermediary (FI), the State Attorney General's Office, the State Department of Health (DOH) and OMIG.

All Affected Persons should follow OHH policy in the event a government agent presents himself or herself at OHH. The same procedure is in place with or without a search warrant being presented. It is important to note that in the past, government agents have attempted to use intimidation to obtain confidential information, including questioning an employee or medical staff member at his or her home. Therefore, the following procedures apply in the event government agents contact any Affected Person, including employees, on or off OHH property.

Affected Persons should:

XVII. Immediately notify the Corporate Compliance Officer as the government agency may be conducting an investigation of OHH. Employees may contact their direct supervisor who is then responsible for contacting the Corporate Compliance Officer. Notification should occur even if it is outside of normal business hours. (Contact is defined to include presenting a search warrant, any requests from governmental agencies to schedule future interviews or meetings with employees and medical staff or for written information under circumstances where the request seems out of the ordinary.)

2. Upon initial contact, the Affected Person should only provide the name and location of the Corporate Compliance Liaison and Corporate Compliance Officer. Do not inadvertently waive personal or OHH's rights such as the attorney-client privilege, the right to counsel and the right against self-incrimination. Affected Persons do not have to answer any questions prior to the appropriate parties' arrival.

The Corporate Compliance Officer will notify OHH's CEO and/or external legal counsel. External legal counsel will direct the investigation, in consultation with the Corporate Compliance Officer, as appropriate and necessary.

Please refer to OHH's Search Warrant and On-Site Investigation from a Government Agency Policy (CC 16-3) for additional instructions.

XVI. COMPLIANCE MONITORING & AUDITING

The Practices recognize the importance of performing routine compliance audits, including self-evaluation of the compliance risk areas identified in 18 NYCRR § 521-1.3(d)), the published government work plans and the Practice Work Plan.

As set forth in OHH's Corporate Compliance Plan, compliance monitoring and auditing procedures will be implemented that are designed to determine the accuracy and validity of the charging, coding and billing submitted to federal, state and private health care programs, contracts with Contractors, and detect other instances of potential misconduct by employees and medical staff and others affiliated with OHH, including the Practices. Monitoring and auditing also play a role evaluating OHH's compliance with applicable federal and state laws, rules and regulations, including New York and federal fraud, waste and abuse rules and Medicaid and Medicare requirements, and in determining the overall effectiveness of the Corporate Compliance Program. It will also include routine auditing and monitoring of the Practices' operations and systems by internal and external auditors with expertise in state and federal Medicaid requirements and applicable laws, rules and regulations, or have expertise in the subject area of the audit, to determine the effectiveness of internal controls designed to prevent or detect errors, and to ensure compliance with internal policies and procedures, as well as applicable federal and state laws, rules and regulations, with a focus on those risk areas identified in 18 NYCRR 521-3(d) and the oversight of any other risk area as may be identified by OIG or OMIG that the Corporate Compliance Liaisons feel is of a medium or high risk that is included on the Practice Work Plan.

The Practices will participate in OHH's system-wide annual compliance monitoring and auditing function, which includes random samplings of records drawn from a cross-section of departments, as well as from the Practices. Specific monitoring and auditing plans will be included in the annual OHH Work Plan, as well as the separate Practice Work Plan established pursuant to this Corporate Compliance Plan, which shall include but not be limited to periodic tests of claims submitted to Medicare, Medicaid, and other health plans.

As a result of internal auditing and self-evaluation, the Corporate Compliance Liaisons, with the assistance of the Corporate Compliance Officer, will establish specific areas to be addressed in the Practice Work Plan, along with those risk areas that may be identified by OIG, OMIG and the OHH Work Plan. This will be accomplished through internal audits as directed by the Corporate Compliance Officer. Where appropriate, the Corporate Compliance Officer will arrange for external audits according to the risk areas identified above and in the OHH Work Plan. Results of self-evaluations will be reported to the Corporate Compliance Liaisons and the Corporate Compliance Officer, who will evaluate the potential for or actual non-compliance. The results of all internal and external audits, or audits conducted by the federal or state government, are also reviewed for risk areas that can be included in the Practice Work Plan.

This provides a system for routine identification of compliance risk areas which is required by OMIG.

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

The Practices hereby adopt and incorporate by reference OHH's Monitoring and Auditing Policy (Policy CC 16-8).

XVII. AUDITING AND MONITORING: SYSTEM FOR ROUTINE IDENTIFICATION OF COMPLIANCE RISK AREAS

The Practices are committed to ensuring that this Corporate Compliance Plan is properly implemented through periodic monitoring and establishment of an annual Work Plan that will list audit priorities based on risk areas the Practices have identified and those identified in published government work plans, such as the OIG and OMIG work plans, that are relevant to the Practices.

The principal activities evaluated under the Work Plan will focus on the following risk areas identified in 18 NYCRR § 521-1.3(d): 1. Billings; 2. Payments; 3. Ordered services; 4. Medical necessity; 5. Quality of care; 6. Governance; 7. Mandatory reporting; 8. Credentialing; 9. Contractor, subcontractor, agent or independent contract oversight; and 10. Other risk areas that are or should with due diligence be identified by OHH through its organizational experience.

Annual Work Plan

The Practices use a variety of sources to develop its Work Plan, including published government work plans, claims denials, self-identified risk areas, past internal investigations and audits, and internal and external risk assessments, as well as authoritative publications from federal and state agencies, including the Centers for Medicare and Medicaid Services (CMS), the New York State Department of Health (NYSDOH) and OMIG as may be appropriate, to assist in its quest to decrease the instances of healthcare fraud and abuse and to determine which items may pose a medium to high risk to the Practices. The Practices' Corporate Compliance Liaisons will work with the OHH Corporate Compliance Officer and Compliance Committee to establish on an annual basis, or as otherwise necessary to comply with any changes in federal and state laws, rules, regulations and/or policies, a work plan for the Practices (the "Practice Work Plan") outlining plans to assess and monitor the Practices' compliance with compliance program requirements, focusing on those specific areas noted above, as well as those that pose a medium to high risk based on the Practices' operations and on any OIG and/or OMIG designated risk areas, as applicable.

The Corporate Compliance Liaisons are responsible for developing the Practice Work Plan and for submitting it to the Corporate Compliance Committee for feedback.

Areas of concern can also arise as a result of planned organization activities, such as areas of growth, process, people or system change. The Practice Work Plan will indicate the items to be reviewed, whether it will be reviewed by internal or external resources, and describes how the review will be conducted. Any changes to the Practice Work Plan should be discussed at the Corporate Compliance Committee meetings. The Practice Work Plan should also be shared with the President of the MPN and OHH's Board of Trustees during the first quarter of the year. In addition, the governing board will receive a quarterly update of the Practice Work Plan activities conducted from the Corporate Compliance Liaisons.

XVIII. SYSTEM FOR RESPONDING TO COMPLIANCE ISSUES

OHH will promptly respond to compliance-related concerns and complaints as they are raised and will thoroughly investigate potential or actual non-compliance reported through the hotline or identified through its routine systems described above and promptly and thoroughly determine whether any corrective action is required. An investigation of a suspected violation typically will involve a review of relevant documentation and records, interviews with staff and others involved

in the issue, and an analysis of applicable laws and regulations. The results of such investigations will be thoroughly documented and shared with the Corporate Compliance Committee and the Board on a confidential basis. Outside legal counsel will be consulted, as necessary. In addition, precautions will be taken to ensure that relevant documents to the investigation are not destroyed. Records of an investigation will include a description of the investigative process, copies of interview notes and key documents, a log of witnesses interviewed and documents reviewed, the results of the investigation, and any corrective action taken. The investigation may be conducted by the Corporate Compliance Officer, legal counsel or an outside expert.

Corrective Action

When necessary, corrective action is promptly and thoroughly taken to reduce the potential for recurrence and ensure ongoing compliance with federal and state laws, rules and regulations and the requirements of the Medicare and Medicaid programs.

The Corporate Compliance Officer should be informed of any non-routine returns of overpayments, even if they are not made as part of a formal investigation or audit. If an audit or investigation reveals a systemic billing, coding or claims submission problem, the Corporate Compliance Officer, with the assistance of legal counsel as appropriate, will draft any required corrective action plan. The scope of possible corrective actions may range from refunds of any overpayments, to disciplinary actions, to reporting incidents of fraud and abuse to federal or state authorities. In the event OHH identifies credible evidence or credibly believes that a state of federal law, rule or regulation has been violated, OHH will promptly report such violation to the appropriate governmental entity when required by law, rule or regulation.

All disciplinary actions taken and corrective actions implemented must be thoroughly documented. Progress reports will be prepared on a periodic basis that list each corrective action item and identify what actions have been taken on each item. Where a violation subject to self-disclosure is suspected, including to the OIG or OMIG, the Corporate Compliance Officer will consult with the CEO, and external legal counsel as appropriate.

XIX. COMPLIANCE PROGRAM EFFECTIVENESS

In conjunction with the annual review of Practices' Corporate Compliance Plans and Work Plans, the Practices' Corporate Compliance Plan shall also be reviewed at least annually by the Corporate Compliance Committee, Corporate Compliance Liaisons and Corporate Compliance Officer to evaluate the effectiveness of the Plan and to determine if changes and/or revisions or corrective actions are necessary. Reviews will include but not be limited to on-site visits, interviews with Affected Persons, and reviews of records. The design, implementation and results of the annual effectiveness review, and any corrective action implemented, will be documented. The results of the annual evaluation shall be shared with the CEO, the President of the MPN, senior management, members of the Corporate Compliance Committee, and the OHH's Board of Trustees for consideration.

Demonstrations of effectiveness will include, but not be limited to:

- Reports made to the Corporate Compliance Liaisons and the Corporate Compliance Officer (either directly, through the hotline, or on the report form), which indicate Affected Persons are aware of the Corporate Compliance Program and the reporting systems and lines of communication available.
- Written reports that summarize specific compliance reviews/internal audits that were conducted. Ideally, there will be reviews conducted proactively from

knowledge of a high-risk area along with reviews conducted reactively due to reported concerns.

- Attendance rates for annual compliance training at 95% or above.
- Refunds made (an explained as applicable) to Medicare or Medicaid for overpayments received in error. Subsequently, refunding of overpayments discovered as part of an internal audit is typically a routine procedure at the conclusion of the internal audit. Alternatively, if overpayments are found on a case-by-case basis, those too will be refunded timely and appropriately.*
- Completion of any self-assessment tool or module that is provided by the OMIG.

*When any overpayments are discovered, the Practices must determine how widespread the overpayment issue is and if there was any intention to defraud the government. OIG and OMIG both have 'self-disclosure procedures' that are available to providers online that provide details on how to self-disclose any overpayments. The Practices follow the self-disclosure protocols, if necessary, with the assistance of external legal counsel.

The Practices hereby adopt and incorporate by reference OHH's Response to Overpayments Policy (CC 16-23) and Self-Disclosure Under the OMIG Self-Disclosure Program and OIG Self-Disclosure Protocol (CC 16-25).

XX. BILLING & CLAIM SUBMISSION PROCESS

When claiming payment for professional services of the Practices, we have an obligation to our patients, third-party payors, and the Federal and State governments to exercise diligence, care and integrity with respect to billing and claims submission. The right to bill the Medicare and Medicaid programs, conferred through the award of a provider number or supplier number, carries a responsibility that may not be abused.

The Practices are committed to maintaining the accuracy of every claim they process and submit. Many people throughout Oneida Health Hospital have responsibility for entering charges, credits and procedure codes. Each of these individuals is expected to monitor compliance with applicable billing rules. With the implementation of a new HIS system, a main focus has been placed on both charge and credit reconciliation in all departments, units, clinics, etc. Additionally, the Practices recognize the importance of a solid charge master, as well as effective policies and procedures to govern accurate charging and crediting.

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

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

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

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

The Practices hereby adopt and incorporate by reference OHH's Billing and Claims Submission Policy (CC 16-9), which staff of the Practices may consult for additional instructions.

XXI. OIG EXCLUSION CHECKS

The Practices are prohibited from employing or contracting with any individual, organization, contractor or vendor who is listed by the OIG and/or the OMIG as debarred, excluded or otherwise ineligible for participation in Federal and State Health Care Programs. This prohibition is necessary to ensure the Practices receive appropriate Federal and State healthcare program reimbursement for items and/or services provided to patients. The Practices are prohibited from billing for any services ordered by a provider that has been excluded.

As affiliates of OHH, the Practices follow OHH's process to ensure that all required exclusion screening occurs, including during the employment process and credentialing for providers. Additionally, on a monthly basis, a third-party vendor performs exclusion checks on behalf of the Practices (e.g., Kchecks and Green Security). OHH also requires its Contractors to comply with these exclusion screening requirements. For any Contractor that is required to maintain an effective compliance program, the Corporate Compliance Officer will consider the most efficient manner in which to ensure that required monthly screenings are conducted. Results of exclusion checks and related activities will be promptly shared with the Corporate Compliance Officer and other appropriate compliance personnel.

The Practices hereby adopt and incorporate by reference OHH's Exclusion Checks Policy (CC 16-47).

XXII. FRAUD & ABUSE LAWS FROM DEFICIT REDUCTION ACT (DRA)

The Practices take health care fraud and abuse very seriously. It is our policy to provide information to all Affected Persons about:

- The Federal False Claims Act;
- The New York State False Claims Act;
- Remedies available under these acts;
- Other applicable state, civil or criminal laws;
- How employees, contractors and agents can use these regulations;
- Federal whistleblower protections available to employees, contractors and agents; and
- Procedures that the Practices have in place to detect health care waste, fraud and abuse.

Employees will also find this information in the employee handbook provided at the time of your employment.

The Federal False Claims Act allows a civil action to be brought against a health care provider who:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment to any employee;
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid;
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid[5].

A person can also be found liable under the False Claims Act who acts in reckless disregard of the truth or falsity of information.[6] In addition, individuals subject to this Corporate Compliance Plan should keep the following in mind:

- As of May 2009, there no longer needs to be an "intent" of getting a false claim paid. The false claim cases going to court are now based on whether the false record or statement was "material" to getting the claim paid;
- Prime contractors who receive federal funds who submit false claims from a subcontractor could have a false claim liability; and
- A health care provider who receives monies to which they are not entitled, and retains those monies, known as an overpayment, can also be liable for a false claims liability;

Examples of a false claim include:

- Billing for procedures not performed;
- Violation of another related law. For example, a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs (monies) for referrals);
- Billing for a procedure performed, when the actual procedure performed was similar (but not identical) to what was billed and what was billed provided a higher reimbursement rate;
- A provider who improperly "retains" an overpayment; and
- "Reckless disregard", for example: (1) knowingly submitting claims for deceased beneficiaries and (2) making up false medical record charts in order to submit false claims.

Remedies:

- A Federal false claims action may be brought by the U.S. Department of Justice Civil Division, the United States Attorney and/or the Office of Inspector General.
- An individual may bring what is called a qui tam action (or whistleblower lawsuit). This means the individual files an action on behalf of the government against a health care provider. If the individual wins, the individual and government shares in the settlement.
- Violation of the Federal False Claims Act (FCA) is punishable by a civil penalty of between $14,308 to $28,619 per violation per false claim[7], plus three times the amount of damages incurred by the government (treble damages). As of May 2009, there is a mandatory liability for government costs in the recovery of penalties and damages for dependents that have violated the FCA.

[5] 31 U.S.C. section 3729 (a)
[6] 31 U.S.C. section 3729(b)
[7] Amounts applicable to civil penalties assessed after December 22, 2022; penalty amounts are subject to adjustment each year.

- A statute of limitations says how much time may pass before an action may no longer be brought for violation of the law. Under the FCA, the statute of limitations is six (6) years after the date of violation or three (3) years after the date when material facts are known or should have been known by the government, but no longer than ten (10) years after the date on which the violation was committed, whichever occurs last.

The Practices hereby adopt and incorporate by reference OHH's Health Care Waste, Fraud and Abuse Policy (CC 16-10)

XXIII. WHISTLEBLOWER PROTECTION

OHH has non-intimidation and non-retaliation policies in place to promote "good faith" participation in its Compliance Program, including but not limited to reporting potential issues, participating in the investigation of issues, self-evaluations, audits, remedial actions, reporting instances of intimidation or retaliation, and reporting potential fraud, waste or abuse to the appropriate officials state and federal entities.

- Employees who choose to become a whistleblower have rights that are protected under whistleblower protections.
- Federal and New York State law prohibit an employer from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. The employee is entitled to all relief necessary to make the employee whole[8].
- FCA liability extends to any conspiracy to violate any requirement of the FCA like retaliation against whistleblowers, which is against the law.
- The whistleblower employment discrimination protection has extended to employees, contractors and agents engaged in "any other efforts to stop a violation of the FCA".
- With the implementation of the Federal Enforcement and Recovery Act (FERA) of 2009, there are new procedural provisions that allow the government to intervene beyond the statute of limitations, in an existing qui tam suit by amending a complaint with new allegations.
- Whistleblowers also have protection under the NY Not-for-Profit Corporation Law § 715-B and NY Labor Law §§ 740 and 741.

Any form of intimidation or retaliation should be reported immediately. Any individual found to have violated OHH's *Whistleblower Protection* policy will be subject to disciplinary action up to and including termination of employment or affiliation with OHH. A copy of this policy may be found on OHH's external website.

The Practices hereby adopt and incorporate by reference OHH's Whistleblower Protection Policy (CC 16-33).

XXIV. RETENTION OF RECORDS

All records of OHH, including the Practices, shall be maintained according to Medicare, Medicaid, and all federal, state and local regulatory guidelines, and any other record retention policy of Oneida Health Hospital. All records demonstrating OHH has adopted, implemented and operated an effective compliance program shall be retained for a period of no less than six (6) years from the date of implementation, or any amendments thereto were made, and copies of such records shall

[8] 31 U.S.C 3730 (h)

be made available to the NYS Department of Health, OMIG, or MFCU upon request.

The Practices hereby adopt and incorporate by reference OHH's Record Retention Policy (RC.005).

XXV. AFFECTED PERSON'S ROLE & RESPONSIBILITIES

The Practices rely on all Affected Persons to ensure they continue to operate in a legal and ethical manner. Without involvement and engagement, the Corporate Compliance Program cannot succeed. As such, all Affected Persons, as applicable, are responsible for:

- Being honest in all interactions with patients, co-workers, supervisors, management and medical staff.
- Participating in good faith in OHH's Compliance Program, including promptly raising questions and concerns.
- Becoming familiar with Oneida Health Hospital's Code of Conduct, and the policies and regulations that relate to one's job responsibilities and acting in accordance therewith.
- Refusing to participate in unethical or illegal conduct.
- Listening to questions or complaints made by patients, family members or visitors and notifying supervisors/managers of those complaints.
- Reporting any concerns about potential non-compliant behavior to the Corporate Compliance Liaisons, a member of the Corporate Compliance Committee, or the Corporate Compliance Officer.

Compliance Reporting Form

***Instructions**: Any person affected by Oneida Health Hospital's risk areas, including employees, the chief executive officer of Oneida Health Hospital and other senior administrators, managers, and contractors, agents, subcontractors and independent contractors (collectively "Contractors"), and governing body and corporate officers ("Affected Persons") of Oneida Health Hospital, including the hospital and all its departments and health centers, the Extended Health Care Facility, Oneida Health Hospital's affiliated physician practices, and any other department of entity which is part of Oneida Health Hospital, as appropriate, may complete this form if you feel there was/is a situation of potential non-compliance with NY State regulations, federal regulations, OHH's own policies or the OHH/ECF or OMP/OMS Corporate Compliance Plans.*

Please complete and return this form by mail or e-mail to Renee Olmsted, the Corporate Compliance Officer, at rolmsted@oneidahealth.org for review

Date:	
Name & department of individual writing this report (unless you wish to remain anonymous*):	
How do you wish the Compliance Officer to contact you for follow-up? Please provide phone number and/or email address.	Check one: Email/phone: ___at OHH/Practices ___at Home Phone number:_____ Email address: _____
What are you reporting? Please explain your concern and why it concerns you.	
What are the date(s) or time frame for your concern?	
Department(s) involved:	
Any other individuals and/or department(s) involved (unless they wish to remain anonymous):	
Are there any supervisors or department managers you have spoken to about your concern? YES- NO	If yes, what actions did they take and what were you told?
Any additional information you would like to share?	

***Note:** The Corporate Compliance Officer will maintain all reports in a confidential manner unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG, or law enforcement, or such disclosure is required during a legal proceeding or otherwise required by law. It is helpful for you to allow this to be handled confidentially rather than anonymously, so that the Corporate Compliance Officer can contact you with any questions and provide you with the outcome of the investigation. If you choose to remain anonymous, the Corporate Compliance Officer may not be able to further the investigation or notify you directly with the results of any investigation. However, you may contact the Corporate Compliance Officer directly at extension 2117 or by phone 315-361-2117 if you have any further information or questions.*

CONFIDENTIAL

Schedule 1

The Practices, as affiliates of Oneida Health Hospital ("OHH"), fall within OHH's Corporate Compliance Program structure. This Corporate Compliance Plan has been developed to describe how the compliance program for the Practices works in conjunction with the OHH Corporate Compliance Program, and applies to the following divisions, including all Affected Persons affiliated with or providing services on behalf of those divisions:

- **Oneida Medical Practice, P.C.**, including the following divisions:
  - Gastroenterology Specialists
  - Orthopedic Care, including addition of Hamilton Ortho
  - Neurology Care
  - Ear Nose and Throat Care
  - Podiatry Care
  - Vascular Care
  - Oneida Health Family Care at Camden
  - Quick Care, Oneida & Camden
  - TriValley Family Medicine, Canastota & Vernon
  - Pulmonary Specialists
  - Breast Care
  - Behavioral Health – Collaborative Care Model
  - Oneida Health Family Care
  - Oneida Surgical Specialists
  - Oneida, Camden and Rome Pediatrics

- **Oneida Medical Services, PLLC** (d/b/a Oneida Health Women's Care)

Schedule 2

Oneida Health
Corporate Compliance Committee
CHARTER

I. PURPOSE

The purpose of the Corporate Compliance Committee (the 'Committee') is to assist and support the Oneida Health Hospital Board of Trustees and Compliance & Privacy Officer & Risk Management Director ('Corporate Compliance Officer') of Oneida Health Hospital ('OHH'), including the hospital and all its departments and health centers, the Extended Health Care Facility, OHH's affiliated physician practices (the 'Practices'), and any other department or entity which is part of Oneida Health Hospital (collectively the 'Hospital') in fulfilling its oversight of the Hospital's Compliance Program, including the detection and prevention of fraud, waste and abuse, and violations involving laws, regulations or policies. The Committee's responsibilities shall generally include coordinating with the Corporate Compliance Officer and Corporate Compliance Liaisons to ensure the business of the Hospital is conducted in an ethical and responsible manner consistent with the Compliance Program, which may include: overseeing, administering and managing the Corporate Compliance program and its performance; fostering and maintaining a culture of compliance throughout the organization; implementing all compliance policies and procedures in accordance with the Corporate Compliance Plan, evaluating strategic compliance issues and making recommendations regarding proposed action and corrective action plans; and monitoring appropriate follow up and improvement.

II. COMPOSITION

The Corporate Compliance Officer shall chair the Committee. In addition to the Corporate Compliance Officer and the Corporate Compliance Liaisons, the Committee shall be comprised minimally of representatives from the Senior Leadership team, including: the Chief Medical Officer, Chief Operating Officer, Chief Nursing Officer, Chief Financial Officer, VP Medical Practice Network, Chief Information Officer, Nursing Home Administrator and VP Human Resources of OHH. In addition, the following Hospital Directors shall also serve as members of the Committee: All MPN Compliance Liaisons (Medical Director, Practice Directors), Patient Financial Services (Patient Accounting) and Revenue Integrity Director, Finance Controller, as well as the MPN Central Business Office Manager, Patient Access Director, Pharmacy Director, and Directors/Managers of Ancillary Departments.

Committee members shall be appointed by the Chair of the Committee, with recommendations from the OHH Board or Chief Executive Officer as to representatives from Hospital Administration, and shall serve until their successors shall be duly appointed. The Committee reports directly and is accountable to the President and Chief Executive Officer of OHH and the OHH Board of Trustees. Committee members shall enhance their knowledge of healthcare compliance by participating in educational programs conducted or provided by the Hospital and external compliance related educational offerings.

III. MEETINGS

The Committee shall meet monthly or more frequently as circumstances dictate. Attendance may be in person or by secure remote connection. Reports regarding Committee meetings will be provided to the OHH Board on a regular basis, but no less than quarterly.

IV. RESPONSIBILITIES AND DUTIES

The Committee's responsibilities and duties shall include:

- Receive and act upon reports and recommendations of the Corporate Compliance Officer,
- Conduct periodic analysis of the current health care environment, the legal requirements to which the Hospital and affiliates are subject, and identification of specific risk areas;
- Review and assess the Hospital's Compliance Program, including OHH's and the Practices' Compliance Plans, policies and procedures, as well as other existing policies and procedures that address risk areas, and making recommendations accordingly on an annual basis to ensure the effectiveness of the Compliance Program and determine if any revision(s) or corrective action(s) is required;
- Advocating that required modifications of the Hospital's Compliance Program are adopted and implemented;
- Coordinating with the Corporate Compliance Officer to ensure written compliance policies and procedures and standards of conduct are current, accurate and complete;
- Work with Hospital departments to develop standards of conduct and policies and procedures to ensure effective implementation of the Compliance Program;
- Monitor internal systems and controls implementing Compliance Program's standards, policies and procedures which incorporate them into daily Hospital and affiliate operations;
- Maintain appropriate strategies to promote compliance and the detection and correction of potential violations, including the hotline or other fraud reporting mechanisms;
- Monitor the status of internal and external audits conducted pursuant to the Compliance Program and implementing corrective and preventive action;
- Coordinating with the Corporate Compliance Officer to ensure training and education is provided as required, including supporting educational offerings to Affected Persons, including the Board, Medical Staff, employees, and Contractors;
- Submit an annual work plan to the Board of Trustees regarding the activities of the Compliance Program and any recommended changes or amendments.
- Coordinate with the Corporate Compliance Office to ensure communication and cooperation by Affected Persons on compliance-related issues, including:
    - Review and discuss issues brought to the attention of compliance (i.e. hotline calls, etc.);
    - Review and discuss patient complaints in regard to compliance;
    - Review and discuss HIPAA privacy issues & activities;
    - Review and discuss HIPAA Security issues & activities;
    - Review and discuss CC Code of Conduct activities;
    - Review and discuss 340B Program issues & activities; and
    - Review and discuss EMTALA issues;

- Review and make recommendations on compliance auditing and monitoring activities and coordinate with the Corporate Compliance Officer to ensure required internal and external audits, as appropriate, are conducted;
- Receive and discuss updates and status on rules and regulations that govern the Hospital and affiliates;
- Review and discuss any provider compliance issues;
- Review and approve the annual compliance work plan and resulting activity while monitoring OIG and OMIG work plans and focus areas;
- Reviewing and updating, as necessary, the Compliance Committee Charter annually and maintaining minutes demonstrating the annual review, including if no changes to the Charter are necessary;
- Advocating that the Corporate Compliance Officer has the necessary funding, resources and staffing, as appropriate, to adequately perform compliance-related functions;
- Ensuring effective risk identification and remedial actions, including refunding of overpayments, are implemented;
- Providing assistance to the Corporate Compliance Officer in fulfilling his/her oversight responsibility for the Hospital's Compliance Program, policies and procedures; and
- Performing any other duties as directed by the Board of Trustees of OHH.

Approved and adopted by the Board of Trustees:

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Chairman, Board of Trustees **Date**

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Corporate Compliance Officer **Date**

Est. 1/5/23
Revised 4/20/23, 1/15/24
Signed by the Board 1/29/24
Signed by the Board 1/20/25
Signed by the Board 1/26/26