CORPORATE COMPLIANCE PLAN

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

AFFILIATES OF
ONEIDA HEALTH HOSPITAL

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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., Oneida Medical Services, P.L.L.C., and Genesee Physician Practice, P.L.L.C., and describe the compliance obligations for all board members, officers, managers, employees, physicians, consultants, independent contractors, students and volunteers ("Affected Persons") at the above entities.

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 521.3(c). 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:

- Implementing written standards, policies and procedures;
- Designating a Compliance Officer or contact;
- Conducting appropriate training and education;
- Developing open lines of communication;
- Responding appropriately to detected offenses and developing corrective action;
- Conducting internal monitoring and auditing;
- Enforcing disciplinary standards through well publicized guidelines; and
- Creation and enforcement of a policy of non-intimidation and non-retaliation for good faith participation in the compliance program.

II. COMMITMENT STATEMENT

Oneida Health Hospital and its affiliated entities, including its group physician practices, Oneida Medical Practice, P.C. ("OMP"), Oneida Medical Services, P.L.L.C. ("OMS"), and Genesee Physician Practice, P.L.L.C. ("GPP") (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, OMS and GPP (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 Compliance Liaisons responsible for the day-to-day operation of the compliance plan for the Practices who will report to Oneida Health Hospital's Corporate Compliance Director, and the respective governing boards of the Practices. The Board of Trustees (the "Board") for OHH is the governing body over the OHH Compliance Program.

- The Compliance Liaisons also serve as members of Oneida Health Hospital's Corporate Compliance Committee. The Board receives the monthly Corporate Compliance Committee minutes and a semi-annual report presented by OHH's Corporate Compliance Director. 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 general compliance-related training and education programs for all Affected Persons. OHH employs a customized electronic training system, Inservice Solutions, which tracks completion of employees' required compliance training annually. All Affected Persons attend either a general orientation session or receive one-on-one training with the Corporate Compliance Director covering compliance and privacy related topics. Additional specialized compliance training is conducted for specific departments that are deemed as having higher risk operations, such as the coding and billing functions. Training and education provides all Affected Persons with an understanding of our compliance program, legal requirements applicable to OHH, and knowledge of our compliance related policies and procedures. Orientation and annual training create an opportunity to convey our OHH's commitment to ethical and legal conduct and remind staff of their role in compliance. Board Members will receive annual compliance training. Non-employees receive periodic training, including receipt of a packet that includes our Corporate Compliance training PowerPoint presentation. Vendors receive compliance training via "Sympler," a full-service, web-based vendor credentialing service, which oversees our vendor credentialing and compliance process. OHH providers receive annual compliance training at the semi-annual Medical Staff meeting, as well as in individual meetings at their offices with the Compliance Director.

- Implementation of a 'reporting and response mechanism' to receive reports of potential non-compliance or concerns and a procedure for the Corporate Compliance Director or 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 Director. To facilitate detection of potential non-compliant conduct, it is necessary for all individuals affiliated with OHH to feel comfortable in reporting compliance issues. It is critical that OHH maintain open lines of communication and an environment is created whereby staff does not have reason to fear intimidation or retaliation for reporting.

- Implementation of a process to respond to any allegations of potential non-compliance, 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. An in-depth investigation occurs for each credible allegation or concern reported or identified to determine the extent, causes and seriousness of the situation. If possible, the non-compliant conduct is halted immediately and the effects of the non-compliant conduct are mitigated. OHH's corrective actions often take aim at reducing the likelihood of similar instances or reoccurrence in the future.

- Use of periodic monitoring activities and conducting internal audits and self-evaluations to determine the rate of compliance with specific regulations and to decrease the risk of non-compliance. 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 physicians, providers (nurse practitioners, physician assistants), staff, vendors or independent contractors that are listed on the OIG or OMIG exclusion website as excluded providers from the Federal and State health care program. This means neither OHH nor the Practices may receive reimbursement from Medicare or Medicaid for any physician, provider or vendor services 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 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 internal 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, and encouraging or directing active or passive non-compliant behavior. Enforcing disciplinary standards is important not only to give the Compliance Program credibility, but also to demonstrate OHH's integrity and commitment to compliance and desire to prevent recurrence and ensure effectiveness.

- Creation of a policy of non-intimidation and non-retaliation for good faith participation in OHH's Compliance Program. It is important to create a culture where fear is not a deterrent to reporting concerns.

- Creation 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.

These commitment statements follow the recommended structure for the seven elements of a corporate compliance program as promulgated by the OIG Compliance Program Guidance and the eight elements of a provider compliance program from Title 18 of the Codes, Rules and Regulations of the State of NY, Part 521 'Provider Compliance Programs', effective July 2009.

III. 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. *Please refer to OHH's Administrative Policy 1-101 "Code of Conduct and Disruptive Behavior" and CC 16-45 "Compliance Code of Conduct."*

The Code of Conduct applies to all Affected Persons. The following is a 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 **team work, 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.

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 Director ("Corporate Compliance Director");
- OHH Corporate Compliance Officer ("Corporate Compliance Officer");
- 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[1].

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

[1] 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.

Practices have named Compliance Liaisons, who are responsible for the day-to-day operation of this Corporate Compliance Plan.

The Compliance Liaisons ensure appropriate oversight of planning, design, implementation, and maintenance 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 Director.

The Compliance Liaisons of the Practices also serve as members of the Corporate Compliance Committee. These individuals have complete and unrestricted access to information, employees and medical staff required to complete the designated corporate compliance responsibilities.

V. THE COMPLIANCE LIAISONS' RESPONSIBILITIES

- Responsible for day-to-day operation of the Practices' Corporate Compliance Plan.
- Report directly to the respective Presidents of the Practices and the Corporate Compliance Director 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.
- Meet with personnel of the Practices to discuss any concerns about potential non-compliance.
- Initiate follow-up for any compliance reports made, including document reviews, claims review, policy review and staff interviews.
- Report to the Corporate Compliance Director, the governing bodies of the Practices, and the Board of OHH.
- Serve as members of the Corporate Compliance Committee.
- Ensure any overpayments received are properly and timely refunded by the Practices' accounting offices and are documented for future reference.
- Perform internal audits of areas designated by the Practice Work Plan and other areas as identified throughout the year.
- Appoint additional staff to assist in the performance of internal audits, as deemed necessary.
- Provide an annual report to the Corporate Compliance Director and the respective governing boards of the Practices 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.
- Ensure compliance with OHH's policies regarding the Notice of Privacy Practices (HIPAA Policies 1-3 and 1-4) and disclosure of protected health information (HIPAA Policy 1-15).

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

As provided under Section IV of OHH's Corporate Compliance Plan, the Affected Persons of Practices and others have a variety of methods they may use to 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' Compliance Liaisons (who in turn can seek assistance from the Corporate Compliance Director, if necessary).
- Call the Corporate Compliance Director 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 confidentially. Only the Corporate Compliance Director has access to retrieve these calls.
- Complete the Compliance Reporting Form (Form #01209) and submit the completed form directly to the Corporate Compliance Director (by inter-office mail, regular mail or in person).*
- Email the Corporate Compliance Director at rolmsted@oneidahealthcare.org

*The Compliance Reporting Form can be found outside of the ACF Human Resources office, the ECF hallway near the nursing offices, and on the OHH Intranet using the path: Corporate, Compliance, and click on the Corporate Compliance Report Form. In addition, the report form is located on Oneida Health Hospital's external website to provide non-employees with greater accessibility to report potential compliance issues to the Corporate Compliance Director at http://www.oneidahealthcare.org/compliance-report-form.

When making a report to the Corporate Compliance Hotline or completing a report form, individuals have the option of remaining anonymous.

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

While you have the option of remaining anonymous when making a report to the Hotline or completing a report form, it will help the Corporate Compliance Director in responding if you identify yourself. All reports via the confidential method will be kept confidential, whether requested or not, unless the matter is turned over to law enforcement.

Where issues of non-compliance are identified by, or reported to a Compliance Liaison, he/she will contact the Corporate Compliance Director to initiate a response to all reports made within a reasonable time frame, but no later than ten (10) business days. 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 Director 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 of the outcome of their report, to the extent deemed appropriate, by the Corporate Compliance Director.

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.

The Corporate Compliance Director, with assistance from the Practices' 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 against any individual who acts in good faith** in raising a question or 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

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. This training shall cover the following required elements:

A. Compliance issues: Training and education must include:
   1. guidance on dealing with compliance issues;
   2. how to communicate compliance issues to appropriate compliance personnel; and
   3. guidance on how potential compliance problems are investigated and resolved.

B. Compliance expectations:
   1. Training and education must include the following related to written compliance program and policies:
      i. expectations related to acting in ways that support integrity in operations;
      ii. written policies and procedures that describe compliance expectations; and.
      iii. written policies and procedures that implement the operation of the compliance program.
   2. Training and education must include the following related to required training and education:
      i. compliance training at orientation; and
      ii. Periodic compliance training.
   3. Training and education must include the following reporting requirements:
      i. training materials must identify who the designated employee is; and
      ii. methods for anonymous and confidential good faith reporting of potential compliance issues as they are identified must be included.
   4. Training and education must include disciplinary policies related to the compliance program, including:
      i. expectations for reporting compliance issues;
      ii. expectations for assisting in the resolution of compliance issues;

iii. sanctions for failing to report suspected problems;
iv. sanctions for participating in non-compliant behavior;
v. sanctions for encouraging, directing, facilitating, or permitting non-compliant behavior; and
vi. expectations that compliance-related disciplinary policies are fairly and firmly enforced.

5. Training and education must include information about non-intimidation and non-retaliation for good faith participation in the compliance program.
6. Training and education will be given using a method that is reasonably expected to be understood by the individuals required to receive training.

C. Compliance program operation:

1. Training and education must identify the employee vested with responsibility for the day-to-day operation of the compliance program and include how the compliance function interacts with management and the Board.
2. Training and education must include information about the system for identifying compliance risk areas.
3. Training and education must include information about the system for self-evaluation of compliance risk areas, including internal audits and, as appropriate, external audits.
4. Training and education must include information about the system for responding to compliance issues, including:
   i. Written policies and procedures that provide guidance on how potential compliance problems are investigated and resolved.
   ii. A system in effect for responding to compliance issues as they are raised.
   iii. A system in effect for responding to compliance issues as identified in the course of audits and self-evaluations.
   iv. A system in effect for correcting compliance problems promptly and thoroughly.
   v. A system in effect for implementing procedures, policies, and systems as necessary to reduce the potential for recurrence.
   vi. A system in effect for identifying and reporting compliance issues to DOH or OMIG.
   vii. A system in effect for refunding Medicaid overpayments.
5. Training will also include up-to-date contact information for the Corporate Compliance Director and up-to-date training policies and procedures.

Initial compliance training for all Affected Persons is incorporated into the general orientation process or received via a one-on-one training session with the Corporate Compliance Director. Individuals who attend general orientation must 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 corporate compliance policies and procedures.

Mandatory annual training for all employees is provided online through 'Inservice Solutions'. Specialized training is also provided on a periodic basis to certain departments and individuals as directed by the Corporate Compliance Director, including members of the governing boards, medical providers and non-medical staff of the Practices, as necessary. Non-employees receive a packet of information on OHH's compliance program, including the Corporate Compliance training PowerPoint presentation provided to OHH employees, and are provided with an

opportunity to ask questions and receive responses from the Corporate Compliance Director regarding the materials or other compliance concerns they may have. Non-employees are required to sign and return an acknowledgment form indicating they have received, read and understand the materials provided to the Corporate Compliance Director.

Specialized training is also provided to certain groups of non-employees (e.g., vendors and contractors) who receive privacy and compliance training as necessary, including screening by Symplr, OHH's vendor credentialing service. Students are also provided privacy and compliance training followed by a written test. Additional privacy and compliance information for these groups is provided in the non-employee handbook. Guards, sitters, and students are also provided privacy and compliance training. Additional privacy and compliance information for these groups is provided in the non-employee handbook.

Periodic compliance training and education sessions are developed and scheduled by the Corporate Compliance Director to provide all Affected Persons associated with the Practices with information on compliance issues, expectations and the operation of the Corporate Compliance Program. Attendance and participation in these education programs is a condition of continued employment. Attendance is tracked and enforced. Failure to meet minimum prescribed requirements will result in disciplinary action, including possible termination.

The Practices hereby adopt and incorporate by reference OHH's Compliance Training and Education Policy (CC 16-7), which provides additional instructions.

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 521.3 (a)(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 521.3 (a)(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 521.3 (a)(3): 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.

D. 18 NYCRR 521.3 (a)(4): 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.

E. 18 NYCRR 521.3 (a)(5): Mandatory reporting
1. Report, repay, and explain all overpayments.
2. Required reporting of compliance issues for all Affected Individuals.
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.

F. 18 NYCRR 521.3 (a)(6): Credentialing
1. Regularly check accuracy and comprehensiveness of credentialing process. a. Identify Affected Individuals 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 Individuals are on those lists. CMS and BOC recommend checking the excluded party lists monthly.

G. 18 NYCRR 521.3 (a)(7): Other risk areas that are or should with due diligence be identified by the provider.
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 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 - Patient Accounting Department's Response to Overpayments Found Within their Department***
- ***CC 16-24 - 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

OMIG requires all providers to certify to the OMIG office that an effective compliance program is in place that meets the requirements specified as outlined above and the eight required elements. The certification is a form that the respective Presidents of the Practices file during the month of December of every year attesting to the effectiveness of the Compliance Plan as required pursuant to New York State Social Services Law 363-d.

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 outlines the seven elements of a compliance program (as referenced in our Commitment Statement in Section II, above). The OIG issues a yearly Work Plan, which is updated on a periodic basis, revealing those designated high-risk areas that have potential for healthcare fraud and abuse. To that end, the Practices will use the guidance and OIG Work Plan to assist in its quest to decrease the instances of healthcare fraud and abuse, including performing a yearly review of the OIG Work Plan to determine which items may pose a medium to high risk to the Practices. The Practices' Compliance Liaisons will work with the OHH Corporate Compliance Director and 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 Compliance Liaisons or the OHH Corporate Compliance Director using one of the many methods of reporting described below.

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 Compliance Program and how they impact day-to-day activities with not only services provided, but also business functions[2].

- 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.

[2] 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 Director.

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*. 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*.

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.

All Affected Persons 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 describes sanctions for (1) failing to report suspected problems, (2) participating in or facilitating non-compliant behavior, and (3) encouraging, directing or permitting active or passive non-compliant behavior.

Sanctions, which are penalties imposed, can result in not only disciplinary action, but also the removal of certain employment privileges, contract penalties, 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.

Affected Persons may also be subject to disciplinary action for:

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

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

While it is very unlikely, an on-site Federal 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 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 the appropriate steps should a Government Agent present 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 about providers, including questioning an employee or medical staff member at his or her home residence. Therefore, the following steps apply to government agents who may contact an employee or agent on or off the property.

Affected Persons should:

1. Immediately notify their direct supervisor.

2. The direct supervisor should immediately notify the Compliance Liaison or Corporate Compliance Officer or Corporate Compliance Director after receiving a contact from governmental agencies who may be conducting an investigation of OHH. (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.)

3. Upon initial contact, the Affected Person should only provide the name and location of the Compliance Liaison, Corporate Compliance Officer and Corporate Compliance Director. Do not inadvertently waive personal or OHH 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 or Corporate Compliance Director will notify external legal counsel. External legal counsel will direct the investigation, in consultation with the Corporate Compliance Officer and Corporate Compliance Director.

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 regular, periodic compliance audits, including self-evaluation of the compliance risk areas identified by OIG, OMIG 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 primarily to determine the accuracy and validity of the charging, coding and billing submitted to federal, state and private health care programs and detect other instances of potential misconduct by employees and medical staff. It will also include the oversight of any risk area identified by OIG or OMIG that the 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.

As a result of internal auditing and self-evaluation, the Compliance Liaisons, with the assistance of the Corporate Compliance Director, will establish specific areas to be addressed in the Practice Work Plan, along with those risk areas identified by OIG, OMIG and the OHH Work Plan. This will be accomplished through internal audits as directed by the Corporate Compliance Director. Where appropriate, the Corporate Compliance Director will arrange for external audits according to the risk areas identified above and in the OHH Work Plan. Results of a self-evaluation will be reported to the Compliance Liaisons and the Corporate Compliance Director, who will evaluate the potential for or actual non-compliance.

This provides a system for routine identification of compliance risk areas which is required by OMIG. OMIG requires a mandatory evaluation of four areas on a regular basis: (1) credentialing of providers (2) mandatory reporting (3) governance and (4) quality of care.

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. 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 the OIG and OMIG Work Plans that are relevant to the Practices.

The principal activities evaluated under the Work Plan will include: 1. billings; 2. payments; 3. medical necessity and quality of care; 4. governance; 5. mandatory reporting; 6. credentialing; and 7. other risk areas that are or should with due diligence be identified by OHH.

Annual Compliance Work Plan

The OMIG publishes a yearly Work Plan, which is updated throughout the year, revealing those designated high-risk areas that have potential for healthcare fraud and abuse. To that end, the Practices use the OMIG Work Plan to assist in its quest to decrease the instances of healthcare fraud and abuse, including performing a yearly and periodic reviews of the OMIG 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 OHH Corporate Compliance Director and Compliance Committee to establish a yearly work plan for the Practices (the "Practice Work Plan") focusing on those specific areas that pose a medium to high risk based on the Practices' operations and on OMIG's designated risk areas.

The Compliance Liaisons are responsible for developing the Practice Work Plan and for submitting it to the Corporate Compliance Committee for feedback. The Practice Work Plan highlights the medium and high-risk areas that have been identified by both the OIG and OMIG work plans, as well as any focus areas that the Corporate Compliance Director and Compliance Liaisons feel are warranted in terms of compliance activity. Types of risks might include regulatory, legal, financial or operational functions. 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 respective governing boards of the Practices and OHH's Board of Trustees during the first meeting of the year. In addition, the governing boards will receive a semi-annual update of the Practice Work Plan activities conducted from the Compliance Liaisons.

XVIII. SYSTEM FOR RESPONDING TO COMPLIANCE ISSUES

OHH will respond to compliance-related concerns and complaints and will investigate potential or actual non-compliance identified through the hotline or through its routine systems described above. 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 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. At the discretion of the Board, the investigation may be conducted by the Corporate Compliance Director, legal counsel or an outside expert.

Corrective Action

The Corporate Compliance Director should be informed of any 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 Director, with the assistance of legal counsel as appropriate, will draft any required corrective action plan ("CAP"). The CAP will list each billing practice or other compliance issue that does not meet the applicable requirements and specify what action should be taken to correct the practice. The CAP will include the development of new policies and procedures to prevent recurrence of the issue as necessary. For each item listed in the CAP, deadlines will be established by which the corrective action must take place. 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.

All corrective actions 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. Decisions whether to disclose the results of investigations or audits to federal or state authorities are made by the Board based upon recommendations of the CEO, Corporate Compliance Director and the Compliance Committee, with the assistance of legal counsel, as necessary.

XIX. COMPLIANCE PROGRAM EFFECTIVENESS

In conjunction with the annual review of OHH's Corporate Compliance Plan and Work Plan, the Practices' Corporate Compliance Plan shall also be reviewed annually by the Corporate Compliance Committee, Compliance Liaisons and Corporate Compliance Director to evaluate the effectiveness of the Plan and to determine if changes and/or revisions are necessary. The annual evaluation shall be promptly submitted to the respective governing boards of the Practices and OHH's Board of Trustees for consideration.

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

- Reports made to the Compliance Liaisons and the Corporate Compliance Director (either directly, through the hotline, or on the report form), which indicates staff is aware of the Corporate Compliance Plan and the reporting systems 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 a concern reported.
- Attendance rates for annual compliance training at 95% or above.
- Refunds made 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 the self-assessment tool 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 intentional and/or widespread systemic compliance issues that resulted in significant overpayments. The Practices can 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, we recognize the importance of a solid charge master as well as 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 Director. 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 the 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 possible to prove fraud was committed against the government easier 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 CHECK FOR PROVIDERS & EMPLOYEES

The Practices, are prohibited from employing or contracting with any employee, agent 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 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 verify that new employees (using Commercial Investigations) and providers are not excluded from the Medicare or Medicaid program. This occurs during the employment process and credentialing phase for providers. Additionally, on an ongoing basis, OHH submits information to a third-party vendor (Kchecks, Symplr) who performs the exclusion checks on behalf of the Practices.

The Practices also adopt the following OHH policies with regard to OIG Exclusion Checks:

- ***Vendor/Contractor Exclusion Checks (CC 16-6),***
- ***Employee Exclusion Check (CC 16-5), and***
- ***Physician Exclusion Checks (CC 16-11).***

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.

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[3].

A person can also be found liable under the False Claims Act who acts in reckless disregard of the truth or falsity of information.[4] 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 $11,181 and $22,363 per false claim[5], 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.
- 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

[3] 31 U.S.C. section 3729 (a)
[4] 31 U.S.C. section 3729(b)
[5] Amounts applicable to civil penalties assessed after January 29, 2018; penalty amounts are adjusted on January 15 of each year.

no longer than ten (10) years after the date on which the violation was committed, whichever occurs last.

XXIII. WHISTLEBLOWER PROTECTION

- Employees who choose to become a whistleblower have rights that are protected under whistleblower protections.
- Federal law prohibits 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[6].
- 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.
- With the new FCA revisions, the new provisions are allowed to be retroactively applied to pending qui tam cases that were reported prior to May 2009.
- Whistleblowers also have protection under the NY Not-for-Profit Corporation Law § 715-B and NY Labor Law §§ 740 and 741.

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

XXIV. AFFECTED PERSON'S ROLE & RESPONSIBILITIES

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

- Being honest in all interactions with patients, co-workers, supervisors, management and medical staff.
- Becoming familiar with Oneida Health Hospital's Code of Conduct, and the policies and regulations that relate to one's job responsibilities.
- 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 Compliance Liaisons or the Corporate Compliance Director.

[6] 31 U.S.C 3730 (h)