ONEIDA HEALTH HOSPITAL

ACUTE CARE FACILITY
&
EXTENDED CARE FACILITY
&
ARTICLE 28 HEALTH CENTERS

CORPORATE COMPLIANCE PLAN

Reviewed:	October 2005
	April 2007
	June 2008
	September 2008
Revised:	September 2009
	December 2012
	March 2013
	October 2014
	April 2016
	August 2018

Dear Board Members, Fellow Employees and Associates:

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 Hospital Board members, officers, managers, and other workforce members, including employees, trainees, providers, consultants, independent contractors, students, temporary workers and volunteers ("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, 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's acute care facility, extended care facility as well as the Article 28 Health Centers. In addition, this plan describes how the compliance program for the Acute Care and Extended Care facilities, as well as the Article 28 Health Centers overlaps with Oneida Health Hospital's affiliates, including Oneida Medical Practice, P.C. ("OMP"), Oneida Medical Services, ("OMS") PLLC and Genesee Physician Practice, PLLC (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 Corporate Compliance Director.

Please read through the plan and contact either myself or the Corporate Compliance Director 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,
Gene F. Morreale, Chief Executive Officer

ONEIDA HEALTH HOSPITAL

CORPORATE COMPLIANCE PLAN

I. PURPOSE AND APPLICABILITY

The purpose of the OHH Corporate Compliance Program is to provide guidelines designed to reflect Oneida Health Hospital's commitment to promoting prevention, detection of health care fraud and resolution of instances of potential misconduct within day-to-day operations.

This Corporate Compliance Plan applies mainly to the following Oneida Health Hospital entities:

- Acute Care Facility (ACF);
- Oneida Health Hospital's Article 28 outpatient departments, including the Oneida Health Cancer Care in affiliation with Roswell Park, Chittenango Internal Medicine, Chittenango Family Care, Canastota Lenox Health Center, Verona Health Center and Maternal Health Center; and
- Extended Care Facility or ECF.

This Plan describes the compliance obligations for Affected Persons at the above entities. In addition, this manual outlines the compliance obligations for Oneida Health Hospital's affiliated practices at OMP, OMS and GPP. While those entities maintain a separate compliance program, the programs overlap as described below in the section titled "OHC's Compliance Oversight Structure."

The goals of the Corporate Compliance Program initiative are to:

- Build upon our mission and our values;
- Provide a common understanding of OHH's expectations for proper conduct through the organization's policies and the code of conduct;
- Integrate the Corporate Compliance Plan for the Acute Care Facility, Extended Care Facility and Article 28 Health Centers with OHH's affiliate practices at OMP, OMS and GPP in order to create a centralized and effective process for Affected Persons to ask about compliance related concerns and management to address those concerns;
- Provide a framework for dealing with difficult, complex or confusing issues such as interpretation of regulations or ethical concerns; and
- To ensure that Federal and State regulations are enforced and third-party guidelines are followed including those from health insurance companies.

II. COMPLIANCE PROGRAM COMMITMENT STATEMENT

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) and 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.

Oneida Health Hospital has demonstrated a commitment to compliance by adopting these elements of a Corporate Compliance Program through the following actions:

- Development of this Corporate Compliance Plan and a related Corporate Compliance Plan for OMP, OMS and GPP, including designation of Corporate Compliance Liaisons responsible for the day-to-day operation of the compliance program for those entities. The Corporate Compliance Liaisons for OMP/GPP and OMS will report to OHH's Corporate Compliance Director and will serve on OHH's Corporate Compliance Committee to implement and enforce the policies described in this document at these associated practices.

- 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.

- Designation of a Corporate Compliance Officer, a Corporate Compliance Director, Corporate Compliance Liaisons and a Corporate Compliance Committee who are charged with the responsibility of operating and monitoring the Corporate Compliance Program. The Compliance Director is primarily responsible for the day-to-day operations of the OHH Compliance Plan and works collaboratively with the OMP/GPP and OMS Compliance Liaisons. In addition, the Board of Trustees at OHH ("the Board") is the governing body over the OHH Compliance Program, and also oversees the compliance program for OMS/GPP and OMP.[1] The Board receives the monthly Corporate Compliance Committee minutes and a semi-annual report presented by the Corporate Compliance Director. This designation is critical to ensuring that the Corporate Compliance Plan remains visible, active, effective and accountable.

- Development and implementation of general compliance-related training and education programs for all Affected Persons as set forth in more detail in this plan. OHH employs a customized electronic training system, Inservice Solutions, which tracks completion of employees' required compliance training annually. All Affected Persons attend a general orientation session or receive one-on-one training with the Compliance Director covering compliance, EMTALA 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 programs, legal requirements applicable to OHH and knowledge of our compliance related policies and procedures. 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. 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

[1] The governing board and officers for OMP/GPP and OMS also oversee the compliance programs for those entities, as described in the OMP, OMS and GPP Corporate Compliance Plan.

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 Compliance Director to address them. These include a report form, an anonymous hotline and open lines of communication via email, phone or face to face meetings with the 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-compliance 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 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. Oneida Health Hospital institutes a yearly compliance Work Plan outlining potential focus areas of risk and opportunity. This Work Plan serves as the guide for our yearly activity. OMP and OMS will also develop an annual Work Plan outlining particular areas of risk and opportunity, specific to their activity.

- Implementation of a process that verifies that Oneida Health Hospital 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 programs. This means OHH cannot receive reimbursement from Medicare or Medicaid for any physicians, providers or vendors 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 for Compliance Program Policy CC 16-30* for Affected Persons of OHH and medical staff 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. *Please refer to OHH's Whistleblower Protection Policy CC 16-33.*

- Creation of a process to refund any overpayments that Oneida Health Hospital discovers it may have received inadvertently from Medicare, Medicaid or third party payer. OHH has a refund tracking process that is triggered by an entry into the Meditech system, which kicks off an auto-email notification of the overpayment. These overpayments are also tracked in an excel spreadsheet and monitored by Compliance. *Please refer to OHH's Response to Overpayments Policy CC 16-23*.

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

This Code of Conduct serves as the foundation for the organization's compliance, privacy, customer service, and patient safety programs. It reflects the behaviors consistent with laws and regulations and with our commitment to caring. Affected Persons will, at all times, act in a way to meet the requirements of this mandatory compliance program and applicable law and regulation. Affected Persons are expected to conduct business in a manner that supports integrity in OHH's operations. Any conduct contrary to this expectation will be considered a violation of the compliance program, and related policies and procedures.

Please refer to Administrative Policy LD 1-101 "Code of Conduct and Disruptive Behavior" and *CC 16-45 "Compliance Code of Conduct."* These Code of Conduct policies apply 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 payers.

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. WHERE TO GO FOR ASSISTANCE – REPORTING A CONCERN

In an attempt to keep the communication lines to the Compliance Director accessible to all Affected Persons affiliated with OHH, OMP, and OMS, Oneida Health Hospital provides a variety of methods that staff and others may use to report potential compliance issues as they are identified. This includes a method for anonymous and confidential good faith reporting for all individuals affiliated with OHH. The following methods are available:

- Discuss the question or concern with the direct supervisor (who in turn can seek assistance from the 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 voice mail anonymously and confidentially. Only the 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, on the OHH Intranet using the path: Corporate, Compliance, and clicking on the Corporate Compliance Report Form; and on the hospital intranet under Approved documents (form #01209). 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.

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

Please refer to OHH's Compliance Reporting System Policy (CC 16-1)

Note: For employee relation matters, such as performance evaluations, pay rate increases, time off, benefits, etc. please contact the Human Resource Department as you normally would.

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

When making a report to the Hotline or completing a report form, you have the option of remaining anonymous. However, 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.

The Corporate Compliance Director will 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-serve basis, 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, along with relevant department managers and Members of the Corporate Compliance Committee, are responsible for evaluating OHH's training and education needs and ongoing monitoring and auditing activities to prevent the reoccurrence of any incidents of non-compliance.

Please refer to OHH's Internal Investigations and Response Policy (CC 16-2)

VI. NON-INTIMIDATION AND NON-RETALIATION

It is every Affected Person's responsibility to participate in good faith in OHH's compliance program, which includes promptly raising questions or reporting concerns. We rely on this to ensure that our Corporate Compliance Plan is effective. **Oneida Health Hospital 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. Oneida Health Hospital has a Whistleblower Protection Policy (CC 16-33) and is cognizant of the requirements of the New York State Nonprofit Revitalization Act of 2013 for whistleblower protections. OHH requires each person's assistance to identify and report any suspicious behavior or business practices to ensure the opportunity to investigate and correct them when necessary.

VII. COMPLIANCE TRAINING & EDUCATION POLICY

Oneida Health Hospital's compliance training program shall cover the following required elements:

a. Compliance issues: Training and education must include:
    i. guidance on dealing with compliance issues;
    ii. how to communicate compliance issues to appropriate compliance personnel; and
    iii. guidance on how potential compliance problems are investigated and resolved.
b. Compliance expectations:
    i. Training and education must include the following related to written compliance program and policies:
        1. expectations related to acting in ways that support integrity in operations;
        2. written policies and procedures that describe compliance expectations; and.
        3. written policies and procedures that implement the operation of the compliance program.
    ii. Training and education must include the following related to required training and education:
        1. compliance training at orientation; and
        2. Periodic compliance training.
    iii. Training and education must include the following reporting requirements:
        1. training materials must identify who the designated employee is; and

2. methods for anonymous and confidential good faith reporting of potential compliance issues as they are identified must be included.

iv. Training and education must include disciplinary policies related to the compliance program, including:
   1. expectations for reporting compliance issues;
   2. expectations for assisting in the resolution of compliance issues;
   3. sanctions for failing to report suspected problems;
   4. sanctions for participating in non-compliant behavior;
   5. sanctions for encouraging, directing, facilitating, or permitting non-compliant behavior; and
   6. expectations that compliance-related disciplinary policies are fairly and firmly enforced.

v. Training and education must include information about non-intimidation and non-retaliation for good faith participation in the compliance program.

vi. 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:

i. 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.

ii. Training and education must include information about the system for identifying compliance risk areas.

iii. Training and education must include information about the system for self-evaluation of compliance risk areas, including internal audits and, as appropriate, external audits.

iv. Training and education must include information about the system for responding to compliance issues, including:
   1. Written policies and procedures that provide guidance on how potential compliance problems are investigated and resolved.
   2. A system in effect for responding to compliance issues as they are raised.
   3. A system in effect for responding to compliance issues as identified in the course of audits and self-evaluations.
   4. A system in effect for correcting compliance problems promptly and thoroughly.
   5. A system in effect for implementing procedures, policies, and systems as necessary to reduce the potential for recurrence.
   6. A system in effect for identifying and reporting compliance issues to DOH or OMIG.
   7. A system in effect for refunding Medicaid overpayments.

v. 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 via one-on-one training 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 Compliance Plan and to have knowledge of where and how to access corporate compliance policies and procedures.

Mandatory annual training for employees is provided online through 'Inservice Solutions'. Specialized training is also provided on a periodic basis to certain departments and individuals, including Board Members, executives and medical providers. 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. Oneida Health Hospital providers receive annual corporate compliance training at the semi-annual Medical Staff meeting as well as individual meetings in their offices with the Compliance Director.

Specialized training is also provided to certain groups of non-employees (e.g., vendors and contractors) who receive privacy and compliance training on a periodic basis, including screening by the vendor credentialing service known as Symplr. 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 OHH, including providers and non-medical staff at OMP/GPP and OMS, 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.

Please refer to OHH's Compliance Training and Education Policy (CC 16-7) for additional instructions.

VIII. OHC'S COMPLIANCE OVERSIGHT STRUCTURE

The Compliance Oversight Structure at Oneida Health Hospital consists of the following compliance-related roles added to existing positions at OHH:

- Corporate Compliance Director,
- Corporate Compliance Officer,
- Corporate Compliance Liaisons,
- Corporate Compliance Committee, and
- Governance of the OHH and OMP/OMS Corporate Compliance Plans by the OHH Board of Trustees and the governing bodies of OMP/GPP and OMS.

These compliance related positions oversee not only functions at the hospital, but also the nursing home (ECF), outpatient Article 28 clinics, off-site location and services, and OHH's physician affiliates, OMP, OMS and GPP. These compliance-related roles have been added to the following existing positions at OHH:

- The Compliance Director is also the Director of Risk Management and the HIPAA Privacy Officer;
- The Compliance Officer is also the VP, Medical Affairs/Chief Medical Officer;
- The Corporate Compliance Liaisons also hold managerial positions within OMP/OMS.
- Some Department Directors hold positions on the Compliance Committee; and
- The Board of Trustees and President/Chief Executive Officer (CEO) are ultimately in charge of the governance of the Corporate Compliance Plans for OHH and OMP/GPP and OMS.

These roles have been developed to ensure appropriate oversight of planning, designing, implementing, and maintaining organization-wide Compliance Programs and associated policies and procedures.

These individuals have complete and unrestricted access to information, employees and medical staff required to complete the designated corporate compliance responsibilities.

The Corporate Compliance Director

The Corporate Compliance Director reports to the Vice President of Medical Affairs and serves as the coordinator for all corporate compliance activities and functions in this role on a daily basis. The Corporate Compliance Director is principally responsible for the design, development, dissemination, implementation and oversight of OHH's Corporate Compliance Program. The Corporate Compliance Director's has the following responsibilities:

- Responsible for day-to-day operation of the OHH Corporate Compliance Program.
- Reports directly to the Vice President of Medical Affairs.
- Maintains documentation related to the Corporate Compliance Program, including but not limited to, minutes of the Corporate Compliance Committee meetings, compliance complaints and investigations, as well as the resolution of any complaint investigations.
- Meets with OHH personnel to discuss any concerns about potential non-compliance.
- Initiates follow up for any compliance reports made, including document reviews, claims review, policy review and staff interviews.
- Makes annual verbal and written reports to the Board of Trustees as part of the governance of the Compliance Program.
- Functions as the chairperson to the Corporate Compliance Committee and ensures it meets monthly and there is documentation of all discussion points.
- Ensures any overpayments received are properly and timely refunded by the patient accounting office and documented for future reference**.**
- Performs internal audits of areas designated by the annual compliance Work Plan and other areas as identified throughout the year.
- Appoints additional staff to assist in the performance of internal audits, as deemed necessary.
- Provides a report to specific department managers, senior management and the Corporate Compliance Committee about topics investigated or internal audits conducted.
- Provides individual and small group training as a result of outcomes from internal audits.
- Provides the compliance program portion of general orientation for new employees.
- Monitors the attendance of annual compliance training sessions for all Affected Persons, as applicable, and specific training for selected groups of employees and non-employees.
- Ensures that the annual OMIG compliance certification form is completed, signed, reviewed and filed appropriately by December 31st of every year, unless otherwise specified by OMIG.
- Ensures that the provider credentialing files are audited for accuracy and completeness of specific documents every year.
- Provides revisions to all compliance department related materials on an annual basis.
- Oversees the external audits conducted by Medicare and Medicaid.
- Maintains the privacy of protected health information.
- Ensures OHH's privacy practice policy is followed if disclosure of protected health information is necessary.

The Corporate Compliance Officer

The Corporate Compliance Officer reports to the Chief Executive Officer and the Board of Trustees, as necessary, and serves in an advisory capacity to the Corporate Compliance Director, primarily about financial matters that arise due to claim billings, reimbursements/payments and overpayments. The Corporate Compliance Officer is in charge of coordinating all government or other payer investigations and may seek the assistance of outside legal counsel.

The Compliance Liaisons

The Compliance Liaisons for OMP/GPP and OMS oversee the day-to-day activities of the Corporate Compliance Plan for these affiliated entities and the Article 28 Health Centers, with oversight from the Corporate Compliance Director. Individuals associated with those entities may refer problems or issues to the Compliance Liaisons or directly to the Corporate Compliance Director.

The Corporate Compliance Committee

The OHH Corporate Compliance Committee members consist of management (typically Department Directors), the Corporate Compliance Liaisons for OMP/GPP and OMS, and senior management personnel who, in this Committee's capacity, will serve as an oversight body for OHH's Corporate Compliance Program. The Corporate Compliance Director is the Chairperson for the Corporate Compliance Committee meetings.

These committee members have dual roles to compliance and to their other areas of operational responsibility. Committee Members assist in implementing and operationalizing the Corporate Compliance Plans for OHH and OMP/GPP and OMS, including the advocacy and support of compliance efforts, and are responsible for bringing compliance-related concerns to the meetings so a multiple department approach can be developed and/or participation on sub-committees to decrease the risk of compliance issues.

Governance

The Board of Trustees is the governing body over the OHH Corporate Compliance Plan. In addition, issues from OMP/GPP and OMS get reported up from their governing boards to the Corporate Compliance Committee and onto the Board of Trustees. Each Board member legally has a general 'duty of care' which is defined as the obligation to exercise the proper amount of care in their decision-making process. The three-part duty of care test includes board members acting (1) in good faith, (2) with the level of care that an ordinarily prudent person would exercise, and (3) in a manner that they reasonably believe is in the best interest of OHH.

IX. NYS OFFICE OF MEDICAID INSPECTOR GENERAL (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 applicable compliance policies and procedures that can be found on the hospital intranet. In addition, this plan describes how OHH monitors the effective operations of these particular topics. Additional information can be found at www.omig.state.ny.us

X. 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 Chief Executive Officer files during the month of December of every year attesting to the effectiveness of OHH's Compliance Program. OHH files both the DRA and SSL certification according to regulation.

Our affiliated groups at OMP and OMS will file separate certifications as applicable.

OHH will also seek validation that its third-party billing vendors also process and file the appropriate certifications attesting to effective compliance Programs.

XI. OFFICE OF INSPECTOR GENERAL (OIG) COMPLIANCE GUIDANCE

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 also issues an annual Work Plan with periodic updates revealing those designated high-risk areas that have potential for healthcare fraud and abuse. To that end, Oneida Health Hospital will use the guidance and Work Plan to assist in its quest to decrease the instances of healthcare fraud and abuse. OHH performs a timely review of the OIG Work Plan to determine which items may pose a medium to high risk to OHH and includes those focus areas in its yearly Work Plan.

There are six OIG Compliance Program Guidance Documents that are applicable to OHH's 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 Oneida Health Hospital's Work Plan, and the OMP/OMS Work Plan as applicable, and should bring any potential instance of non-compliance or concern to the attention of his or her direct supervisor or the Corporate Compliance Director using one of the many methods of reporting.

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

XII. 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 following sections below provide examples, not meant to be exclusive, of specific compliance guidelines for many specific departments at OHH and certain specialized functions. These examples describe the broad nature of OHH's Compliance Programs and how they impact day-to-day activities with not only services provided but also business functions.

NURSING EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Maintaining patient confidentiality.
- Assuring that patient consent has been obtained when necessary.
- Monitoring that quality of care is provided to all patients regardless of where the services are provided (outpatient setting, emergency room, inpatient status).
- Ensuring accurate and safe administration of medications by observing the 5 "rights" of medication administration (the ***right dose*** of the ***right drug*** at the ***right time*** to the ***right patient*** by the ***right route***).
- Ensuring nursing services are well documented in an accurate and timely manner in the patient chart.
- Notifying patients of their rights.
- Ensuring security of all patient medical records.
- Accurate charge and credit processing.
- Ensuring proper disposal of syringes, needles and bio-hazardous waste.
- Following universal precautions to protect against blood-borne pathogens.
- Following proper patient inter-hospital transfer and discharge procedures.
- Ensuring the patient is supplied with a discharge plan prior to discharge.
- Timely reporting of unusual patient occurrences.
- Exhibiting behavior that is consistent with the code of conduct.
- Following all departmental policies and procedures.

PATIENT ACCOUNTING AND FINANCE DEPARTMENT EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Billing only for items or services that are actually provided.
- Ensuring claims submitted are for medically necessary services or items.

- Reviewing patient account credit balances regularly and making refunds as soon as possible, as appropriate.
- Bringing any potential billing errors to the attention of your supervisor or manager as soon as possible.
- Ensuring claims submitted are supported by a physician or other authorized practitioner's written order.
- Furnishing itemized billing statement to patients, upon request.
- Ensuring payments received are for the correct amount. If not, refunding the accidental overpayment to the appropriate party in a timely manner.
- Accurate charge and credit processing.
- 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.
- Following all departmental policies and procedures.

PATIENT ACCESS / PRE-ENCOUNTER DEPARTMENT EMPLOYEES

- 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 signs the 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.
- Accurately completing the Medicare Secondary Payer Questionnaire when applicable.
- Ensuring the notice of privacy practices is provided to patients.
- Ensuring patients show proof of their identity.
- Utilizing advance beneficiary notices ("ABNs"), when applicable.
- 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.
- Following all department policies and procedures.

ALL EMERGENCY DEPARTMENT PERSONNEL

- Reporting of any potential Corporate Compliance or Privacy concern.
- Ensuring patients receive a medical screening exam prior to obtaining financial or insurance information. (EMTALA)
- Assessing and stabilizing patients before transferring them to another facility.
- Timely and accurately documenting the ED visit in the patient medical record.
- Providing emergency care services to any patient entering the ED regardless of insurance coverage or ability to pay.
- Accurate charge and credit processing.
- Assuring that patient consent is obtained where necessary and where possible.
- Ensuring proper disposal of syringes, needles and bio-hazardous waste.
- Providing, to the best of your ability, privacy to all ED patients (i.e. utilizing curtains and dividers).
- Ensuring patient confidentiality and not inappropriately releasing patient information to the media or unauthorized individuals.
- 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.
- Following all department policies and procedures.

MEDICAL STAFF

- Reporting of any potential Corporate Compliance or Privacy concern.
- Maintaining patient confidentiality.
- Assuring that patient consent has been obtained when necessary.
- Monitoring that quality of care is provided to all patients regardless of where the services are provided (outpatient setting, emergency room, inpatient, and observation status).
- Ensuring services are well documented in an accurate and timely manner in the patient chart.
- Ensuring services provided are medically necessary.
- Accurate credit and charge processing.
- Maintaining the privacy of protected health information.
- Maintaining compliance with all applicable federal and state laws and regulations and The Joint Commission standards with regard to education and state licensure.
- Reporting any issue or concern which infringes on the ability to provide patient care.
- Informing OHH if excluded from participation in any federal health care program, including but not limited to, Medicare and Medicaid, or private insurance plan.
- Exhibiting behavior that is consistent with the code of conduct.
- Following all departmental policies and procedures.

BOARD OF TRUSTEES

- Reporting any potential Corporate Compliance or Privacy concern.
- Overseeing OHH's Compliance Program.
- Reporting any conflicts of interest.
- Maintaining the confidentiality of protected health information and other proprietary OHH information.
- Receiving periodic reports on compliance from the Compliance Director.
- Helping to maintain a culture of compliance where individuals feel free to make reports.
- Ensuring proper follow-up on compliance issues that are reported to the Board.

OTHER AFFECTED PERSONS (e.g., volunteers, students, independent contractors)

- Reporting any potential Corporate Compliance or Privacy concern.
- Being aware of the requirements of OHH's Compliance Program with respect to coding, billing, marketing, etc., as applicable.
- Exhibiting behavior that is consistent with the code of conduct.
- Maintaining the privacy of protected health information.
- Following all department policies and procedures.

RADIOLOGY /CARDIOLOGY/PHYSICAL THERAPY DEPARTMENT EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Obtaining requisition and signed practitioner orders prior to performing any requested testing/procedure.
- Clarifying any illegible practitioner orders prior to performing the test/procedure.
- Obtaining medical history from the patient or medical record to ensure safe and accurate testing and results (i.e. allergies to contrast media, contradictions, panic disorders, etc.).

- Ensuring proper billing by using the appropriate code for the test/procedure.
- Accurate charge and credit processing
- Utilizing advance beneficiary notices ("ABNs"), when applicable.
- 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.
- Following all department policies and procedures.

LABORATORY DEPARTMENT EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Completing lab tests when ordered by a physician or authorized practitioner with diagnosis information.
- Ensuring standing orders are reasonable and necessary through the routine monitoring to ensure orders are renewed every six months, if appropriate.
- Accurate charge and credit processing.
- Ensuring any lab IT errors are not systematic in nature and if so audit claims.
- Ensuring compliance OSHA regulations and other laboratory specific accrediting bodies.
- Utilizing advance beneficiary notices ("ABNs"), when applicable.
- 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.
- Following all department policies and procedures.

CARE TRANSITION SERVICES EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Following the specific mandatory reporting requirements for Federal and State Health Care Programs.
- Monitoring hospital inpatient admissions for medical necessity, reasonableness of services and quality of care.
- Ensuring that patient care is rendered at the appropriate level and site of service.
- Ensuring that insurance companies have authorized patient services.
- Monitoring and trending readmission rates.
- Ensuring discharge planning services are intact.
- 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.
- Following all department policies and procedures.

PATIENT SAFETY AND QUALITY EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Monitor quality of care for patients in the medical assistance program, as mandated by OMIG.
- Understand the convergence of quality and compliance by ensuring patients are receiving quality patient care and patient safety is paramount.
- Ensure all mandatory reporting requirements are met for Federal and State Health Care programs.
- Accurate and timely NYPORTS reporting to the NYSDOH.
- Ensure all Core Measure data elements are reporting according to regulation.
- 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.
- Following all department policies and procedures.

HEALTH INFORMATION MANAGEMENT (HIM) DEPARTMENT EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Maintaining the privacy of protected health information.
- Ensuring OHH's privacy practice policy is followed if disclosure of protected health information is necessary.
- Following all departmental policies and procedures.

REVENUE INTEGRITY EMPLOYEES

- Following the National Correct Coding Initiative (NCCI) and ensuring claims are free of coding edits.
- Ensuring accounts are coded and billed based on documentation in each patient's medical record.
- Ensuring the selection of diagnosis information, CPT/HCPCS codes are accurate
- Ensuring admission and discharge information is accurately compiled on each patient so records can be coded.
- Consulting with the individual treating physician when medical record information is vague enough that it cannot be accurately coded.
- Submitting all required data elements to SPARCS at NYSDOH.
- Maintaining knowledge of all of CMS's requirements.
- Accurate charge and credit processing.
- 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.
- Following all departmental policies and procedures.

ARTICLE 28 HEALTH CENTER EMPLOYEES

- 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.
- Accurately completing the Medicare Secondary Payer Questionnaire when applicable.
- Ensuring the notice of privacy practices is provided to 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.

MEDICAL STAFF AND EMPLOYEES AT ALL OMP/GPP AND OMS OFFICES

- 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 the notice of privacy practices is provided to 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.

HOUSEKEEPING AND MAINTENANCE DEPARTMENT EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Following Occupational Safety and Health Administration ("OSHA"). NYSDOH and Joint Commission regulations to ensure compliance.
- Maintaining a clean and safe environment for patients, providers, visitors and employees.
- Complying with Material Safety Data Sheet Instructions ("MSDS").
- Resolving patient and visitor complaints related to the department's operations.
- Exhibiting behavior that is consistent with the code of conduct.
- Maintaining the privacy of protected health information.
- Following all departmental policies and procedures.

MEDICAL STAFF OFFICE (PROVIDER CREDENTIALING)

- Reporting of any potential Corporate Compliance or Privacy concern.
- Ensuring all physicians, nurse practitioners and physician assistants are credentialed appropriately prior to conducting business and providing patient care at OHH.
- Ensuring the credentialing and re-credentialing process meets all applicable state laws and Joint Commission regulations that include verification of education and state licensure, verification of DEA license, copies of malpractice insurance, checking of the national practitioner data bank and NYS professional misconduct reporting site along with the OIG and OMIG exclusion site.
- Monitoring the compliance of annual health assessments, tuberculosis tests and infection control training required by NYS.
- 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.
- Following all departmental policies and procedures.

EXTENDED CARE FACILITIES EMPLOYEES

- Reporting of any potential Corporate Compliance or Privacy concern.
- Notifying residents of their rights.
- Ensuring quality of care through quality assurance activities and processes.
- Documenting all pertinent information in the resident medical record in a timely manner.
- Developing and revising resident care plans as necessary.
- Discussing advance directive orders with patients and their families upon admission.
- Ensuring accurate, safe administration of drugs.
- Ensuring proper disposal of syringes, needles and bio-hazardous waste.
- Ensuring accuracy of registration information by verifying **all** resident information including insurance information.
- Ensuring residents receive and acknowledge their Admission Agreement and Financial Policy.
- Making an effort to collect all co-payments and deductibles due from patients.
- Accurately completing of the MDS.
- Accurate charge and credit processing.
- Ensuring compliance with CMS Final Rule as applicable
- Ensuring security of all patient medical records.
- Maintaining and promoting a safe, sanitary environment.
- Reporting incidents of mistreatment, neglect, or abuse to the administrator of the facility and other officials, as required by law.
- Promoting safe and proper use of physical or chemical restraints.
- 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.
- Following all departmental policies and procedures.

XIII. DISCIPLINARY ACTIONS & SANCTIONS

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 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.

After an investigation, if the concern reported requires disciplinary action, the disciplinary process will proceed per policy as outlined in the *Human Resources Disciplinary Policy HR 11* and *Progressive Disciplinary and Sanction Policy for Compliance Program 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. OHH will enforce its disciplinary policies fairly and firmly.

Sanctions, which are penalties imposed, can result in not only disciplinary action, but also the removal of certain employment privileges, contract penalties, and discharge from employment or termination of the individual's affiliation with OHH. In some cases, civil and/or criminal prosecution from a government agency against an employee or medical staff member may be possible. Senior management may need to be involved in recommending any OHH 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 with their department's applicable policies, where reasonable due diligence on the part of the Director or Senior Manager would have led to the discovery of such non-compliance.

XIV. 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 OHH or one of its affiliated entities. Oneida Health Hospital is committed to preparing 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 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 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 Search Warrant and On-Site Investigation from a Government Agency Policy (CC 16-3) for additional instructions.

XV. SYSTEM FOR ROUTINE IDENTIFICATION OF COMPLIANCE RISK AREAS

OHC is 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 OHH has identified and those identified in the OIG and OMIG Work Plans that are relevant to OHH and its various provider entities.

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 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, OHH uses the OMIG Work Plan to assist in its quest to decrease the instances of healthcare fraud and abuse, including performing a periodic review of the OMIG Work Plan to determine which items may pose a medium to high risk to OHH. The OHH Corporate Compliance Director and Compliance Committee will establish a yearly work plan for OHH (the "OHC 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 Corporate Compliance Director and the Compliance Liaisons at OMP and OMS are responsible for developing annual compliance Work Plans, which are submitted to the Compliance Committee for feedback. The Work Plans highlight the medium and high-risk areas that have been identified by both the OIG and OMIG Work Plans, as well as any focus area that we feel is warranted in terms of compliance activity. Types of risks might include regulatory, legal, financial or operational functions. Areas of concern can arise as a result of planned organization activities, such as areas of growth, process, people or system change. The Work Plans will indicate the items to be reviewed, whether they will be reviewed by internal or external resources, and describe how the review will be conducted.

Any changes to these Work Plans should be discussed at the Compliance Committee meetings. The Work Plans should also be shared with the governing boards during the first meeting of the said year. In addition, the Board of Trustees will receive a semi-annual update of Work Plan activities conducted.

Please contact the Corporate Compliance Director or the OMP or OMS Compliance Liaisons to review a copy of the current year's Work Plan.

Compliance Monitoring & Auditing

Oneida Health Hospital recognizes the importance of performing regular, periodic compliance audits, including self-evaluation of the compliance risk areas identified by OIG, OMIG and the applicable Work 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 to 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 OHH feels is of a medium or high risk that is included on our internal OHH Work Plan.

Random samplings of records drawn from a cross-section of departments will be conducted on an annual basis. Specific monitoring and auditing plans will be included in the annual compliance Work Plan. This will include periodic tests of claims submitted to Medicare, Medicaid, and other health plans. Auditing will be used to review the accuracy of the work of coding and billing personnel and patient registration representatives, as well as appropriate, accurate and timely documentation. For quality of care/medical necessity reviews, claims review will also include care provided by nursing and medical staff.

Self-evaluation of the areas identified in the OHH Work Plan and the OMP/OMS Work Plan will be accomplished through internal audits as directed by the Corporate Compliance Director and/or Compliance Liaisons. Where appropriate, the Corporate Compliance Director will arrange for external audits according to the risk areas identified above. Results of a self-evaluation will be reported to the Corporate Compliance Director, who will evaluate the potential for or actual non-compliance.

The Compliance Director is primarily responsible for coordinating formal audits; however, the audits themselves may be performed by compliance staff, billing staff, or external auditors. Auditors will have broad access to records and personnel. The Compliance Director is responsible for investigating incidents discovered by the audits, systemic errors, or reports of suspected noncompliance. The results of the audit process may be communicated to the Compliance Committee, the Board and may be discussed with legal counsel to determine whether any corrective action is required.

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

Please refer to Monitoring and Auditing Policy (CC 16-8) for additional instructions

XVI. SYSTEM FOR RESPONDING TO COMPLIANCE ISSUES

OHC 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 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, Compliance Director and the Compliance Committee, with the assistance of legal counsel, as necessary.

XVII. COMPLIANCE PROGRAM EFFECTIVENESS

The Corporate Compliance Plans and Work Plans shall be reviewed annually by the Corporate Compliance Committee, Corporate Compliance Officer 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 Board of Trustees for consideration.

Demonstrations of effectiveness will include but not be limited to:

1. Reports made to the Compliance Director or the OMP/GPP and OMS Compliance Liaisons (either directly, through the hotline, or in report form), which indicate that staff is aware of the Compliance Program and the reporting systems available.
2. 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 by a concern reported.
3. Attendance rates for annual compliance training at 95% or above.
4. Corporate Compliance Committee meeting minutes that demonstrate the topics addressed and actions taken. These minutes will be placed in the monthly Board of Trustees packets for its review.
5. Refunds have been 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.*
6. Completion of the self-assessment tool provided by the OMIG.

*When any overpayments are discovered, OHH 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. OHH can follow the self-disclosure protocols if necessary, with the assistance of external legal counsel.

Please refer to Policies CC 16-23 and CC 16-25 for additional instructions related to Self-Disclosures and Overpayments.

XVIII. BILLING AND CLAIMS SUBMISSION POLICY

When claiming payment for OHH for professional services, we have an obligation to our patients, third party payers, 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.

OHC is committed to maintaining the accuracy of every claim it processes and submits. 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. 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 Program 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 against the government easier based on the revised law by widening the definitions of various key words and phrases.

Please refer to Billing and Claims Submission Policy (CC 16-9) for additional instructions.

XIX. OIG EXCLUSION CHECK POLICY FOR PROVIDERS AND EMPLOYEES

The OIG and OMIG have authority to exclude individuals and entities from the Federal and State Health Care Programs. The OIG and OMIG also have the authority to assess penalties to providers that violate the law by employing, contracting with or billing for services ordered by an excluded individual or entity. An individual or entity is most commonly excluded for civil or criminal health care fraud and abuse.

Oneida Health Hospital is 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 Care Programs. This prohibition is necessary to ensure OHH receives appropriate Federal and State Health Care Program reimbursement for items and/or services provided to patients. We are also prohibited from billing for any services ordered by a provider that has been excluded.

Any employee, agent or vendor who is charged with criminal offenses related to health care, must be removed from direct responsibility for or involvement in any Federal and State Health Care Program until resolution occurs. If resolution results in conviction, debarment or exclusion of the employee, agent or vendor, the OHH Corporate Compliance Committee must immediately review the case and proceed with termination of the contract or employment.

OHC shall terminate conditional employment or a conditional contract upon receiving results of the individual or organization being excluded from participation in Federal and State Health Care Programs until which time that they are not on the list.

There is a process in place to verify that new employees (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, we submit information to a third-party vendor who performs the exclusion checks on our behalf (e.g., Kchecks, and a vendor credentialing service "Symplr).

Please refer to Vendor/Contractor Exclusion Checks (CC 16-6), Employee Exclusion Check (CC 16-5), and Provider Exclusion Checks (CC 16-11) Policies for additional instructions.

XX. FRAUD & ABUSE LAWS FROM DEFICIT REDUCTIONS ACT (DRA)

Oneida Health Hospital (OHC) takes health care fraud and abuse very seriously. It is our policy to provide information to all employees, contractors and agents 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 OHH has in place to detect health care waste, fraud and abuse.

You will also find this information in the employee handbook provided to you 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[2].

[2] 31 U.S.C. section 3729 (a)

A person can also be found liable under the false claims act who acts in reckless disregard of the truth or falsity of information.[3] In addition, individuals subject to this Corporate Compliance Program 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[4], as well as an assessment of up to three times the amount claimed as damages sustained 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 entities 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 years after the date of violation or three years after the date when material facts are known or should have been known by the government, but in no event, longer than ten years after the date on which the violation was committed, whichever occurs last.

[3] 31 U.S.C. section 3729(b)

[4] Amounts applicable to civil penalties assessed after January 29, 2018; penalty amounts are adjusted on January 15 of each year.

XXI. WHISTLEBLOWER PROTECTIONS

- Employees who choose to become a whistleblower have rights that are protected under the whistleblower protection laws.
- 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[5].
- 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.

Please refer to the Whistleblower Protection Policy (CC 16-33) for additional information.

XXII. RETENTION OF RECORDS

All records of OHH 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.

Please refer to OHH's Record Retention Policy (RC.005) for additional information.

XXIII. AFFECTED PERSON'S ROLE AND RESPONSIBILITY

Oneida Health Hospital relies on Affected Persons to ensure we continue to operate in a legal and ethical manner. Without involvement and engagement, the Corporate Compliance Program cannot succeed. As such, all staff and physicians are responsible for:

- Being honest in all interactions with patients, co-workers, supervisors, management and medical staff.
- Becoming familiar with OHH's Code of Conduct, and specific departmental policies and the regulations that relate to one's job responsibilities.
- Listening to questions or complaints made by patients, family members or visitors and notifying your supervisor/manager of those complaints.
- Reporting any concerns about potential non-compliant behavior to managers, the OMP or OMS Compliance Liaisons, or the Corporate Compliance Director.

[5] 31 U.S.C 3730 (h)

Compliance Reporting Form

Instructions: ***Any Hospital Board member, officer, manager, or other workforce member, including employees, trainees, providers, consultants, independent contractors, students, temporary workers and volunteers ("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 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 or OMP/OMS Corporate Compliance Plans.***

Please complete and return this form by mail or e-mail to Renee Olmsted, the Corporate Compliance Director, for review.

Date:	
Name & department of individual writing this report (unless you wish to remain anonymous*):	
How do you wish the Compliance Director to contact you for follow-up? Please provide phone number and/or email address.	Check one: Email/phone: ___at OHH ___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 Compliance Director will maintain this report in a confidential manner, which means that your identity will not be disclosed unless it is required by law. It is helpful for you to allow this to be handled confidentially rather than anonymously, so that the Compliance Director can contact you with any questions and provide you with the outcome of the investigation. If you choose to remain anonymous, the Compliance Director may not be able to further the investigation or notify you directly with the results of any investigation. However, you may contact the Compliance Director directly at extension 2117 or phone 315-361-2117 if you have any further information or questions.*

EDM (01209) 9/08 Compliance Reporting Form Staff

Revised 09/2008, 9/2009, 12/2012, 3/12/2013, 02/19/15, 1/31/18, 5/18

CONFIDENTIAL

SCHEDULE 1

Oneida Health Hospital ("OHH") Divisions

The OHH Corporate Compliance Plan applies to the following divisions, including all Affected Individuals affiliated with or providing services on behalf of those divisions:

- OHH, including:
  - OHH Acute Care Facility;
  - OHH Extended Care Facility, also known as _____;
  - OHH Article 28 Health Centers, including:
  - _____;
  - _____;
  - _____;

The OHH Corporate Compliance Plan has been developed to describe how the compliance program works for the above entities, but also overlaps with OHH's corporate affiliates. The following corporate affiliates, although they have a separate Corporate Compliance Plan, fall within OHH's Corporate Compliance Program structure:

- Oneida Medical Practice, PLLC, including the following divisions:
  - _____;
  - _____;
  - _____.
- Oneida Medical Services, PLLC, including the following divisions:
  - Women's Health Associates.
- Genesee Physician Practice, PLLC.