ONEIDA HEALTHCARE'S

CORPORATE COMPLIANCE

PROGRAM

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

ELEMENTS OF A CORPORATE COMPLIANCE PROGRAM

New York State Social Services Law 363-d recognizes that Compliance Programs should reflect a provider's size, complexity, resources and culture. However, the statute requires that all compliance programs satisfy the mandatory elements set out in 363-d subdivision 2 and 18 NYCRR 521.3(c). The specific required elements of a Corporate Compliance Program have been issued by the health care branches of the Federal government, the Office of Inspector General (OIG) and the State government, 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
- Creation and enforcement of a policy of non-intimidation and non-retaliation for good faith participation in the compliance program. (OMIG)

COMMITMENT STATEMENT:

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

- The development and distribution of a written code of conduct as well as specific compliance program related policies and procedures that promote the Healthcare Center's commitment to compliance and provide guidance and expectations for all employees. All policies are posted on the hospital intranet for easy accessibility.

- The designation of a Corporate Compliance Officer, Corporate Compliance Director 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 Compliance Program. In addition, the Board of Trustees at OHC is the governing body over the compliance program. The Board receives the monthly Corporate Compliance Committee minutes and a semi-annual report presented by

the Director. This designation is critical to ensuring that the Compliance program remains visible, active, effective and accountable.

- The development and implementation of general compliance-related training and education programs for all employees. OHC also employs a customized electronic training system, Inservice Solutions, which tracks completion of employees required compliance training annually. All new employees attend an orientation session covering compliance and privacy related topics. Additional specialized compliance training is conducted for specific departments that are deemed as having higher risk operations such as the coding and billing functions. Training and education provides staff with an understanding of our compliance program, legal requirements applicable to OHC 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.

- 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 OHC to feel comfortable in reporting compliance issues. It is critical that we create an environment and maintain open lines of communication in which staff do 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 our compliance program to be effective, we must ensure that Oneida Healthcare 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. OHC's corrective actions often take aim at reducing the likelihood of similar instances of reoccurrence in the future.

- Use periodic monitoring activities and conduct internal audits 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, OHC does cooperate and glean insight from external audits conducted by a variety of agencies. Oneida Healthcare also 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.

- Implementation of a process that verifies that Oneida Healthcare has not employed or contracted with physicians, providers (nurse practitioners, physician assistants), staff, vendors or independent contractors that are listed on the OIG or

OMIG exclusion website as excluded providers from the Federal and State health care program. This means OHC 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 us but also one that is used daily when new ordering physicians enter our health system.

- Follows *Human Resources Progressive Disciplinary Policy 2-11* for employee 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 non-compliant behavior etc. Enforcing disciplinary standards is important not only to give the Compliance program credibility, but also to demonstrate OHC'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 OHC's compliance program. It is important to create a culture where fear is not a deterrent to reporting concerns.

- Creation of a process to refund any overpayments that Oneida Healthcare discovers they may have received inadvertently from Medicare, Medicaid or third party payer. These overpayments will be done within 60 days from the date the overpayment is "identified" or by the date any corresponding cost report is due (if applicable).

These commitment statements follow the recommended structure for the seven elements of a Corporate Compliance Program as promulgated by the OIG Compliance Program Guidances 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.

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. *Please refer to Administrative Policy 1-101 "Code of Conduct and Disruptive Behavior" (revision 7/2011).*

The Code of Conduct applies to all hospital board members, officers, managers, employees, physicians, contractors, consultants, board members, students and volunteers. The following is a guide to ethical behavior:

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

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

4. Oneida Healthcare **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 Healthcare'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**.

MEDICAID COMPLIANCE PROGRAM (OMIG)

The Medicaid Fraud Unit in NYS requires providers to have an effective compliance program that addresses, at a minimum, the following items:

- Billings
- Payments
- Medical Necessity and Quality of Care
- Governance
- Mandatory Reporting
- Credentialing (of physicians and providers)
- Other risk areas that should, with due diligence, be identified by the provider

These areas are incorporated into the applicable section of this compliance plan as well as our policies and procedures. Oneida Healthcare will perform a yearly self assessment of the effectiveness of its Corporate Compliance Program using the tools made available on the OMIG website.

OHC has policies that address these topics listed below including but not limited to:

- 16-9 Billing and Claims Submission Policy
- 16-23 Patient Accounting Department's Response to Overpayments Found Within their Department
- 16-24 Organization's Response to Overpayments Discovered as Part of Compliance Program Efforts
- 16-27 Governance for the Corporate Compliance Program
- 16-28 Monitoring of Medical Staff Credentialing & Annual Internal Audit

The OMIG publishes a yearly work plan revealing those designated high-risk areas that have potential for healthcare fraud and abuse. To that end, Oneida Healthcare uses the work plan to assist us in our quest to decrease the instances of healthcare fraud and abuse. We perform a yearly review of the OMIG work plan and determine which items may pose a medium to high risk to OHC and include those focus areas in our yearly work plan.

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 OHC's Compliance program. We will file both the DRA and SSL certification according to regulation.

MEDICARE COMPLIANCE PROGRAM (OIG)

The Office of Inspector General (OIG) is in charge of administering the integrity of the Medicare program. The OIG has numerous Compliance Program Guidances covering a variety of healthcare industry segments. Each Guidance outlines the seven elements of a Compliance Program (as referenced in our Commitment Statement above). The OIG also issues a yearly work plan revealing those designated high-risk areas that have potential for healthcare fraud and abuse. To that end, Oneida Healthcare will use the guidance and work plan to assist us in our quest to decrease the instances of healthcare fraud and abuse. We perform a yearly review of the OIG work plan and determine which items may pose a medium to high risk to OHC and include those focus areas in our yearly work plan.

There are six OIG Compliance Program Guidances that are applicable to OHC'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 employees and agents should be aware of the risk areas identified as well as Oneida Healthcare's work plan 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.

In 2013, Oneida Healthcare will be developing Corporate Compliance Programs for both our Nursing Facility (ECF) and our Captive PC small group physician practices.

COMPLIANCE OVERSIGHT STRUCTURE

The Compliance Oversight Structure at Oneida Healthcare consists of:

- Corporate Compliance Director,
- Corporate Compliance Officer,
- Corporate Compliance Committee, and
- Governance of the OHC Corporate Compliance Program by the Board of Trustees.

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 our Captive PC physician affiliates.

The (above) compliance-related roles have been added to existing positions at OHC.

- The Compliance Director is also the Director of Risk Management and the HIPAA Privacy Officer.
- The Compliance Officer is also the Vice President of Human Resources.
- Some Department Directors hold positions on the Compliance Committee; and
- The Board of Trustees and President / Chief Executive Officer (CEO) is ultimately in charge of the governance of the compliance program.

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'S RESPONSIBILITIES:

- Meet with OHC personnel to discuss any concerns about potential non-compliance.
- Initiate follow up for any compliance reports made including document reviews, claims review, policy review and staff interviews.
- Make semi-annual verbal and written reports to the Board of Trustees as part of the governance of the Compliance Program.
- Function as the chairperson to the Corporate Compliance Committee and ensure it meets monthly and there is documentation of all discussion points.
- Ensure any overpayments received are properly and timely refunded by the patient accounting office and documented for future reference**.**
- Perform internal audits of areas designated by the annual compliance work plan and other areas as identified throughout the year.
- Appoint additional staff to assist in the performance of internal audits, as deemed necessary.

- Provide a report to specific department managers, senior management and the corporate compliance committee about topics investigated or internal audits conducted.
- Provide individual and small group training as a result of outcomes from internal audits.
- Provide the compliance program portion of general orientation for new employees.
- Monitor the attendance of annual compliance training sessions for all employees and specific training for selected groups of employees.
- Ensure 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.
- Ensure that the provider credentialing files are audited for accuracy and completeness of specific documents every year.
- Provide revisions to all compliance department related materials on an annual basis.
- Oversee the external audits conducted by Medicare and Medicaid.
- Maintaining the privacy of protected health information.
- Ensuring OHC's privacy practice policy is followed if disclosure of protected health information is necessary.

REPORTING & RESPONSE SYSTEM - WHERE TO GO FOR ASSISTANCE

In an attempt to keep the communication lines to the Compliance Director accessible to all employees to allow issues to be reported, Oneida Healthcare 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. 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 361-2117.
- Call the OHC Corporate Compliance Hotline at extension 2116 or phone 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 report form and submit the completed form directly to the Compliance Director (by inter-office mail, regular mail or in person). *
- Email the Corporate Compliance Director at rolmsted@oneidahealthcare.org

*The report form can be located outside of the ACF Human Resources office, the ECF hallway near the nursing offices, outpatient PT building , ENT Specialists office, as well as on the OHC Intranet using the path: Corporate, Compliance, and click on the Corporate Compliance Report Form. In addition, the report form is located on Oneida Healthcare's external website.

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

The Corporate Compliance Director will initiate a response to all reports made within two business days when possible. 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.

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 Healthcare 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 OHC's training and education needs and ongoing monitoring and auditing activities to prevent the reoccurrence of any incidents of non-compliance.

NON-INTIMIDATION AND NON-RETALIATION

It is every employees and medical staff's responsibility to promptly raise questions or report concerns. We rely on this to ensure that our Corporate Compliance Program is an effective one. **Oneida Healthcare will not tolerate retribution, intimidation or retaliation against any employee or medical staff who acts in good faith** in raising a question or concern. OHC 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.

COMPLIANCE TRAINING & EDUCATION:

Oneida Healthcare's initial compliance training program at the time of new hire orientation shall:

- Highlight the importance of a Corporate Compliance Program;
- Highlight our customized Corporate Compliance Program and Manual and Report Form;
- Include identified risk areas for applicable departments and OHC; and
- Summarize Federal and State fraud and abuse laws.

This initial compliance training is incorporated into the General Orientation process for all newly hired employees. New employees must complete a written quiz and score 80% or above to receive credit for this training. In addition, each new employee is required to sign an acknowledgement of receipt of the Compliance Manual and knowledge of where and how to access Corporate Compliance policies and procedures.

Mandatory annual training for all employees is provided online through 'Inservice Solutions'. Specialized training is provided to certain groups of departments and individuals, including Board Members.

Periodic compliance training and education sessions will be developed and scheduled by the Corporate Compliance Director. Attendance and participation in these education programs is a condition of continued employment. Attendance will be tracked and enforced. Failure to meet minimum prescribed requirements will result in disciplinary action, including possible termination.

Please refer to Compliance Training Policy (16-7) for additional instructions.

DISCIPLINARY ACTIONS & SANCTIONS

After an investigation, if the concern reported requires disciplinary action, the disciplinary process will proceed per policy as outlined in the *Human Resources Progressive Disciplinary Policy 2-11*.

It is important to note that depending on the severity of the non-compliant behavior, progressive discipline is not required.

It is expected that employees and medical staff will report compliance issues. If it is found that an employee or a group of employees did not report compliance issues that they were aware of, they will be subject to discipline. The OHC's *progressive disciplinary policy* describes sanctions for (1) failing to report suspected problems (2) participating in non-compliant behavior and (3) encouraging or permitting active or passive non-compliant behavior.

Sanctions, which are penalties imposed, can result in not only disciplinary action, but also the removal of certain employment privileges, contract penalties, and discharge from employment and in some cases civil and / or criminal prosecution from a government agency against an employee or medical staff member. Senior management would be involved with recommending any sanctions needed, as this is not an all inclusive list.

Employees and medical staff 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.

OIG EXCLUSION CHECK FOR PROVIDERS & 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 Healthcare 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 Programs. This prohibition is necessary to ensure OHC receives appropriate Federal and state healthcare 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 Program until resolution occurs. If resolution results in conviction, debarment or exclusion of the employee, agent or vendor, the Health Care Center's 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 Programs until which time that they are not on the list.

There is a process in place to verify that new employees 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 (Kchecks and Verirep).

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

FRAUD & ABUSE LAWS FROM DEFICIT REDUCTION ACT (DRA)

Oneida Healthcare (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 OHC has in place to detect health care waste, fraud and abuse.

The Federal false claims act allows a civil action to be brought against a health care provider who:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment to any employee;
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid[1];
- A person can also be found liable under the false claims act who acts in reckless disregard of the truth or falsity of information[2]
- 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;
- 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 procedures 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
- "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.

[1] 31 U.S.C. section 3729 (a)
[2] 31 U.S.C. section 3729(b)

- Violation of the Federal false claims act (FCA) is punishable by a civil penalty of between $5,500 and $11,000 per false claim, plus three times the amount of damages incurred by the government (treble damages). As of May 2009, there is a mandatory liability for government costs in the recovery of penalties and damages for dependents that have violated the FCA.
- A statute of limitations says how much time may pass before an action may no longer be brought for violation of the law. Under the False claims act, 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 no longer than ten years after the date on which the violation was committed.

WHISTLEBLOWER PROTECTIONS

- Employees who choose to become a whistleblower have rights that are protected under the whistleblower protection.
- 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[3].
- 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 false claims act revisions, the new provisions are allowed to be retroactively applied to pending qui tam cases that were reported prior to May 2009.

COMPLIANCE MONITORING & AUDITING

Oneida Healthcare recognizes the importance of performing regular, periodic compliance audits.

Compliance monitoring and auditing procedures will be implemented that are designed primarily to determine the accuracy and validity of the charging, coding and billing submitted to Federal, state and private health care programs and detect other instances of potential misconduct by employees and medical staff. It will also include the oversight of any risk area identified by OIG or OMIG that OHC feels is of a medium or high risk that is included on our internal OHC work plan.

[3] 31 U.S.C 3730 (h)

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. It will include periodic tests of claims submitted to Medicare, Medicaid, and other health plans. It reviews 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.

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

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

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

ANNUAL COMPLIANCE WORK PLAN

As indicated previously, the Compliance Director is responsible for developing an annual compliance work plan and submits it to the Compliance Committee for feedback. This work plan highlights the medium and high risk areas that have been gleaned from 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. Areas of concern can also be as a result of planned organization activities, such as areas of growth, process, people or system change. The work plan will indicate the items to be reviewed, whether it will be reviewed by internal or external resources, and describes how the review will be conducted.

Any changes to this work plan should be discussed at the Compliance Committee meetings. The work plan should also be shared with the Board of Trustees during the first meeting of the said year. In addition, the Board will receive a semi-annual update of work plan activity conducted.

BILLING & CLAIM SUBMISSION PROCESS

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

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

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

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

There are steep fines, penalties and exclusions from the Federal and State Health Care Program that <u>can</u> 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 (16-9) for additional instructions.

<u>COMPLIANCE PROGRAM EFFECTIVENESS</u>

This Corporate Compliance Program and Plan 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:

- Reports made to the Compliance Director (either directly, through the hotline or report form). This indicates that staff is aware of the program and the reporting systems available.

- That there are 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.
- Attendance rates for annual compliance training at 95% or above.
- 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 their review.
- That there have been refunds made to Medicare or Medicaid for overpayments received in error. Subsequently, refunding of overpayments discovered as part of an internal audit is typically a routine procedure at the conclusion of the internal audit. Alternatively, if overpayments are found on a case-by-case basis, those too will be refunded timely and appropriately.* These "overpayments" will be processed within 60 days from the date the overpayment is "identified" or by the date any corresponding cost report is due (if applicable).
- Completion of the self assessment tool provided by the OMIG.

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

Please refer to Policies 16-23, 16-24, 16-25 and 16-26 for additional instructions related to Self Disclosures and Overpayments.

EMPLOYEES ROLE & RESPONSIBILITIES

Oneida Healthcare relies on staff and physicians 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 OHC's code of conduct, and specific department's 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 supervisor/manager of those complaints.
- Reporting any concerns about potential non-compliant behavior to Managers or the Compliance Director