ONEIDA HEALTH HOSPITAL

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

CORPORATE COMPLIANCE PLAN

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Dear Board Members, Fellow Employees, Associates and other Workforce Members:

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

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

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

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

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

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

Sincerely,
Felissa Koernig, JD/MBA, FACHE
Chief Executive Officer

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 and correction of health care fraud, and resolution of instances of potential misconduct within day-to-day operations, including non-compliance with Medicaid and Medicare requirements.

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

- Acute Care Facility (or ACF);
- Oneida Health Hospital's Article 28 outpatient departments and health centers, including the Oneida Health Cancer Care in affiliation with Roswell Park, Cardiology Specialists, Wound Care and Hyperbaric Medicine, , Chittenango Family Care, Canastota Lenox Health Center, and Verona Health Center, (collectively referred to herein as the "Article 28 Health Centers"); and
- Extended Care Facility (or ECF).

This plan describes the compliance obligations for Affected Persons at the above entities. In addition, this plan 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 Section VIII, titled "OHH'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;
- 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 and report 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), 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 deemed necessary for an effective compliance program include:

- Written standards of conduct, policies and procedures;

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

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

- Development and implementation of effective compliance-related training and education programs 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 or review a general orientation session or receive one-on-one training with the Corporate Compliance Officer covering compliance issues, expectations and the operation of the Compliance Program, EMTALA and privacy related topics. Additional specialized compliance training is conducted for specific employees and/or departments that are deemed as having higher risk operations, such as the coding and billing functions. Training and education provides all OHH employees, including the Corporate Compliance Officer and Corporate Compliance Liaisons, the Chief Executive Officer and other senior administrators, managers and members of the Board, with an understanding of our compliance programs, legal requirements applicable to OHH and knowledge of our compliance-related policies and procedures. Compliance education and training is also part of orientation for new employees, and newly appointed compliance officers and Affected Persons, including a chief executive, manager and board member. Orientation and annual training creates an opportunity to convey our organization's commitment to ethical and legal conduct and remind staff

[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.

of their role in compliance. Contractors receive specific privacy and compliance education programs developed by the Corporate Compliance Officer. For Contractors that are also required to maintain an effective compliance program, the Corporate Compliance Officer will consider the most efficient manner in which to provide compliance training, including any training provided directly by the Contractor. OHH providers receive annual compliance training at the semi-annual Medical Staff meeting, as well as in individual meetings at their offices with the Corporate Compliance Officer.

- Implementation of a 'reporting and response mechanism' to answer questions and receive reports of actual and potential non-compliance or concerns and a procedure for the Corporate Compliance Officer 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 Corporate Compliance Officer. To facilitate prevention, detection and correction of actual or potential non-compliant conduct, it is necessary for all individuals affiliated with OHH, including all Medicaid recipients of services from OHH, to feel comfortable in reporting compliance issues. It is critical that OHH maintain open lines of communication and an environment is created whereby Affected Persons do not have reason to fear intimidation or retaliation for reporting. Accordingly, OHH has implemented a policy of non-intimidation and non-retaliation for good faith participation and reporting to create a culture where fear is not a deterrent to reporting concerns. *Please refer to OHH's Whistleblower Protection Policy CC 16-33*.

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

- Use of periodic monitoring activities and internal and external audits and self-evaluations to determine the rate of compliance with specific regulations and to decrease the risk of non-compliance including New York and federal fraud, waste and abuse rules and Medicaid and Medicare requirements, and in determining the overall effectiveness of the Compliance Program. These risk areas tend to change over time as the Federal and State governments change focus and as internal computer applications and processes change. Additionally, OHH does cooperate and glean insight from external audits conducted by a variety of agencies. 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 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 Affected Persons that are listed on the OIG or OMIG exclusion websites as excluded providers from the Federal and State health care programs. OHH cannot receive reimbursement from Medicare or Medicaid for services provided by an Affected Person if they are listed as OIG or OMIG excluded and generally cannot do business with them. This is not only a monthly submission process for OHH, but also one that is used daily, including when new ordering physicians enter OHH's health system.

- Following *Human Resources Disciplinary Policy HR 11* and *Progressive Disciplinary and Sanction Policy for Compliance Program Policy CC 16-30* for Affected Persons of OHH when it has been

determined that compliance policies, regulations, or Federal or State Health Care Program requirements have been violated. Examples of violations include failing to report suspected problems, participating in or facilitating non-compliant behavior or refusing to do so, and encouraging or directing active or passive non-compliant behavior. Enforcing well-publicized disciplinary standards which encourage good faith participation in OHH's Corporate Compliance Program is important not only to give the Corporate Compliance Program credibility, but also to demonstrate OHH's integrity and commitment to compliance and desire to prevent recurrence and ensure effectiveness. With respect to governing board members, disciplinary actions will be taken in accordance with the applicable bylaws of the entity. For Contractors[2], their agreements with OHH will include the right to terminate the agreement in the event the Contractor fails to comply with OHH's Compliance Program as it relates to the risk areas potentially affected by the Contractor.

- Creation and implementation 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 the Corporate Compliance Department. *Please refer to OHH's Response to Overpayments Policy CC 16-23*.

- Creation and implementation of a process to report to appropriate governmental entity(ies) if OHH identifies credible evidence or credibly believes violations of state or federal laws, rules or regulations have occurred where such reporting is required by law, rule or regulation.

These commitment statements follow the recommended structure for the seven[3] elements of a Corporate Compliance Program as promulgated by the OIG Compliance Program Guidance and the from Title 18 of the Codes, Rules and Regulations of the State of NY, Sub-Part 521-1 effective December 28, 2022.

III. WRITTEN POLICIES AND PROCEDURES AND CORPORATE COMPLIANCE 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. OHH's policies and procedures and the Code of Conduct are reviewed annually to determine whether they have been implemented throughout the organization and are being followed, as well as for their effectiveness, to determine if any updates are required. These policies and procedures and the Code of Conduct establish the expectation of ethical behavior and compliant conduct and describe the responsibilities of all Affected Persons in carrying out the functions of the Compliance Program, including OHH's policy for taking disciplinary action for failure to adhere. Affected Persons will, at all times, act in a way to meet the requirements of OHH's mandatory Corporate Compliance Program and comply with all applicable federal and state laws, rules and regulations. 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 Corporate Compliance Program, and related policies and procedures. OHH developed these policies in accordance with its process for drafting, revising and approving policies and procedures.

[2] Consistent with 18 NYCRR § 521-1.3(c), "Contractors" as sometimes used herein collectively refers to contractors, agents, subcontractors, and independent contractors of Oneida Health unless otherwise noted.
[3] While the new regulations provide for eight elements, OMIG guidance notably combines the discussion of the compliance officer and compliance committee into one element (see 18 NYCRR § 521-1; OMIG Compliance Program Guidance, January 2023 (https://omig.ny.gov/compliance/compliance-library)).

Please refer to Administrative Policy HR 068 "Code of Conduct and Disruptive Behavior" and *CC 16-45 "Corporate Compliance Code of Conduct."* These Code of Conduct policies apply to all Affected Persons. The following is a general overall guide to ethical behavior:

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

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

3. Oneida Health Hospital encourages **honesty and integrity** in communication and fair evaluation of programs and persons. This behavior is reflected in our marketing, admissions, purchasing, transfer, discharge and billing procedures. It also guides the organization, employees and agents in their relationships and interactions with other health providers, educational institutions, vendors and 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 Corporate Compliance Officer, Corporate Compliance Liaisons and Corporate Compliance Committee open and accessible to all Affected Persons, Oneida Health Hospital provides a variety of methods for Affected Persons, including Medicaid recipients of services from OHH, to ask compliance-related questions or report potential compliance issues as they are identified, including a method for anonymous and confidential good faith reporting. The following methods are available to all Affected Persons:

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

*The Compliance Reporting Form can be found (1) outside of the ACF Human Resources office, (2) in the ECF hallway near the nursing offices, and (3) on the OHH Intranet. In addition, the report form is located on Oneida Health Hospital's external website (https://www.oneidahealth.org/wp-content/uploads/Compliance-Reporting-Form-Staff-01209-rev-071318.pdf) to provide greater accessibility for the reporting of potential issues of non-compliance to the Corporate Compliance Officer.

When making a report to the Hotline or completing a Compliance Reporting Form (a copy of which is also attached to the plan), individuals shall remain anonymous. If you desire, you can identify yourself to the Corporate Compliance Officer at the time you make the report which will assist the Corporate Compliance Officer in responding. All reports submitted, including reports made via the confidential method, will be kept confidential, unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or such disclosure is required during a legal proceeding or other required by law.

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

The Corporate Compliance Officer will promptly initiate a response to all reports made within a reasonable time frame. Reports will not be responded to on a first-come, first-serve basis, but rather by the nature and extent of potential non-compliance. If necessary, the Corporate Compliance Officer will seek advice from external legal counsel based on the severity of allegations and will report to the NYS Department of Health or OMIG as necessary.

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

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

The Corporate Compliance Officer, in collaboration with relevant department managers, Corporate Compliance Liaisons 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 Corporate 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 (or in the case of employees, no adverse employment consequence or threat of an adverse employment consequence) against any individual who reasonably believes and who, in good faith,** raises a question or reports a perceived concern, including but not limited to, reporting potential issues, investigating issues, self-evaluations, audits and remedial action, and reporting to appropriate officials as provided in New York State Labor Law Sections 740 and 741. Oneida Health Hospital has a Whistleblower Protection Policy (CC 16-33) and is also 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 annual compliance training program shall, at minimum, cover the following required topics:

a. OHH's risk areas and organizational experience;

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

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

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

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

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

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

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

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

Initial compliance training for all new employees, and newly appointed compliance officers and Affected Persons, including a chief executive, manager and board member, and is incorporated into the general orientation process or via one-on-one training with the Corporate Compliance Officer, which includes the required topics set forth above and compliance issues, expectations and the operation of OHH's Compliance Program. Initial exposure to the Compliance Program as a new employee will be via PayCom, a Human Resources platform. Those individuals will have a face to face review at General Orientation. Individuals who complete the compliance training must complete a quiz to receive credit for this training. In addition, Affected Persons are required to sign an acknowledgement of receipt of the Corporate Compliance Plan and to have knowledge of where and how to access OHH's corporate compliance policies and procedures.

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

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

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

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

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

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

VIII. OHH'S COMPLIANCE OVERSIGHT STRUCTURE

The Compliance Oversight Structure at Oneida Health Hospital consists of the following compliance-related roles:

- Corporate Compliance Officer,
- Corporate Compliance Liaisons,
- Corporate Compliance Committee, and

- Governance of the OHH and OMP/GPP and OMS Corporate Compliance Plans by the OHH Board of Trustees and the governing body of OMP/GPP and OMS.

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

- The Corporate Compliance Officer is also the Director of Risk Management and the HIPAA Privacy Officer;
- The Corporate Compliance Liaisons also hold managerial positions within OMP/OMS.
- Some Senior Leaders and Department Directors hold positions on the Corporate 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 designing, adopting, implementing, and maintaining organization-wide Corporate Compliance Programs and associated policies and procedures.

These individuals have complete and unrestricted access to records, documents, information, facilities and Affected Persons, including employees and medical staff, required to complete the designated corporate compliance responsibilities.

The Corporate Compliance Officer

The Corporate Compliance Officer is the focal point of the Compliance Program. The Corporate Compliance Officer also manages the day-to-day oversight of the Compliance Program. The Corporate Compliance Officer is allocated sufficient staff and full resources of OHH necessary to satisfactorily perform the responsibilities for the day-to-day operation of the Compliance Program. The Corporate Compliance Officer serves as the coordinator for all corporate compliance activities and functions in this role on a daily basis. The Corporate Compliance Officer reports directly and is accountable to the CEO, and, as appropriate, the Board of Trustees. The Corporate Compliance Officer is principally responsible for overseeing and monitoring the adoption, implementation and maintenance of OHH's Corporate Compliance Program and evaluating its effectiveness. The primary responsibilities of the Corporate Compliance Officer shall include all of the responsibilities specifically set forth under 18 NYCRR § 521-1.4(b) and as may be further described, but not necessarily limited to the following:

- Responsible for day-to-day oversight of the OHH Corporate Compliance Program.
- Reports directly and on a regular basis, but not less than quarterly, to the Board of Trustees, CEO and the Corporate Compliance Committee of the functioning of the Compliance Program.
- 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 Affected Persons 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.
- 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.
- 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 and external compliance reviews and audits, as deemed necessary.
- Provides a report to specific department managers, senior management and the Corporate Compliance Committee about topics investigated or audits conducted.
- Provides individual and small group training as a result of outcomes from auditing and monitoring activities.
- Provides the compliance program portion of general orientation for new employees and Affected Persons.
- Monitors and tracks 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 "Certification Statement for Providers Billing Medicaid" is completed.
- 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.
- Participate in and receive effective compliance education and training on an annual basis.
- Coordinating all government or other payer investigations and seeking the assistance of outside legal counsel as appropriate.

The Corporate Compliance Liaisons

The Corporate 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 Officer. Individuals associated with those entities may refer problems or issues to the Corporate Compliance Liaisons or directly to the Corporate Compliance Officer.

The Corporate Compliance Committee

The OHH Corporate Compliance Committee operates in accordance with the Corporate Compliance Committee Charter (attached hereto as Schedule 2). In addition to the Corporate Compliance Officer, membership of the Committee minimally consists of senior managers (typically Department Directors), the Corporate Compliance Liaisons for OMP/GPP and OMS, and other senior management personnel who, in this Committee's capacity, will serve as an oversight body for OHH's Corporate Compliance Program. The Corporate Compliance Officer is the Chairperson for the Corporate Compliance Committee meetings. The Compliance Committee meets on a regular basis, but no less than quarterly. The Corporate Compliance Committee reports directly and is accountable to the CEO and the Board through the Corporate Compliance Officer.

These Compliance Committee members have dual roles to compliance and to their other areas of operational responsibility. Committee members, in coordination with the Corporate Compliance Officer, are charged with ensuring OHH is conducting its business in an ethical and responsible manner, consistent with the Compliance Program. The responsibilities of the Corporate Compliance Committee include those responsibilities specifically set forth under 18 NYCRR § 521-1.4(c)(1); assisting in implementing and operationalizing the Corporate Compliance Plans for OHH and OMP/GPP and OMS, including the advocacy and support of compliance efforts; and responsibility for bringing compliance-related concerns to meetings of the Compliance Committee so a multiple department approach can be developed, and/or participating 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 board 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. The Board of Trustees receives compliance reports from the Corporate Compliance Officer on a regular basis, but no less than quarterly.

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

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

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

D. 18 NYCRR 521-1.3 (d)(4), (5): Medical necessity and quality of care
   1. Develop compliance connectivity to quality oversight process as part of the reporting and control structures.
   2. Conduct periodic tracers of care to assess if quality requirements are being met and provide reports to the compliance function.
   3. Develop quality scorecards with resolution of outliers being reported to the compliance function.
   4. Review documentation for completeness and appropriateness of entries.
   5. Tracking and resolution of complaints from clients, patients, and family members.
   6. Reporting of statistics and responses to aberrations of medical necessity and quality issues to the CO to be used for a control test for the effectiveness of the underlying control process.

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

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

F. 18 NYCRR 521-1.3 (d)(7): Mandatory reporting
1. Report, repay, and explain all overpayments.
2. Required reporting of compliance issues for all Affected Persons.
3. Required reporting of compliance issues to DOH and OMIG. Testing periodically on completeness of mandatory reporting of billing, payment, quality, and contractual issues.
4. Quality control of reporting to ensure accuracy and completeness of reports being made.
5. Ensure compliance with applicable mandatory reporting obligations: a. annual SSL certification; b. annual DRA certification; c. SADC certification; and/or d. other regulatory and program reporting.

G. 18 NYCRR 521-1.3 (d)(8): Credentialing
1. Regularly check accuracy and comprehensiveness of credentialing process. A. Identify Affected Persons who must be credentialed. B. Include normal credentialing considerations like primary source verification and licenses.
2. Regularly check the excluded party lists and take appropriate action if Affected Persons are on those lists. OMIG requires OHH to check the excluded party lists monthly.

H. 18 NYCRR 521-1.3(d)(9): Contractor, Subcontractor, Agent or Independent Contract Oversight
1. Determine the areas of greatest risk for violation of the OHH Corporate Compliance Plan for each contractor, subcontractor, agent or independent contractor based on the services provided by the entity.
2. Prepare training and education programs specific to the contractor, subcontractor, agent or independent contractor that apply to the risk areas of non-compliance.
3. Communicate the expectations and requirements for the contractor, subcontractor, agent or independent contractor to comply with the OHH Corporate Compliance Plan

I. 18 NYCRR 521-1.3 (d)(10): Other risk areas that are or should, with due diligence, be identified by the provider through its organizational experience.
1. Determine if your compliance program is covering all risk areas specific to your provider type. BOC recommends Periodic and routine self-assessments and gap analyses because at any particular point in time, risks may change.
2. Assess affiliates' program integrity. Commitments that affiliates (non-employees) are making to the Required Provider will require some level of audit and investigative expertise and activity.
3. Stratify risks within the compliance program. BOC recommends that Required Providers rank risk areas based upon frequency, severity, impact, etc. and address the ones that create the most exposure.
4. Expand risk areas based upon compliance program history and its operations. As compliance issues are identified and resolved, they should be considered risks to be addressed in the future or the resolution tested to be sure that it resolved the problem needing attention. The analysis should include the other six areas discussed above.

5. For associates (non-employees) that provide Medicaid reimbursable services through the Required Provider, determine if they are independently required to have a compliance program and if they have met the annual certification obligation.
6. Monitor compliance with annual certification obligation for associates, if any.

These areas are incorporated into applicable OHH compliance policies and procedures that can be found on the intranet and/or OHH's external website. In addition, this plan describes how OHH monitors the effective operations of these particular topics. Additional information can be found at https://omig.ny.gov/compliance/compliance

X. MEDICAID COMPLIANCE PROGRAM CERTIFICATION

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

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 updates to it Work Plan website monthly revealing those designated high-risk areas that have potential for healthcare fraud and abuse. To that end, Oneida Health Hospital will use the guidance documents and OIG web-based Work Plan and updates to assist in its quest to decrease the instances of healthcare fraud and abuse. OHH regularly reviews updates to the web-based 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 Officer 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 Corporate 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 Corporate 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 Corporate Compliance Officer.
- 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

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

After an investigation, if the concern reported requires disciplinary action, the disciplinary process will proceed per policy as outlined in OHH's *Human Resources Disciplinary Policy HR 11* and *Progressive Disciplinary and Sanction Policy for Compliance Program CC 16-30 (a copy of which can be found on the OHH website).* OHH's disciplinary policies are also incorporated into OHH's training plan and provided during annual compliance training and education.

Sanctions, which are penalties imposed, may include verbal or written warnings and can result in not only disciplinary action, but also the removal of certain employment privileges, contract penalties, suspension and discharge from employment 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 participate in required compliance education and 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 their part would have led to the discovery of such non-compliance.

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

XIV. What to Do in Case of an On-Site Government Investigation or Search Warrant

While it is very unlikely, an on-site government fraud and abuse investigation could occur at 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 a number of government agencies, including , but not limited to, the OIG, Department of Justice (DOJ), Federal Bureau of Investigations (FBI), United States Attorney's Office, the Fiscal Intermediary (FI), the State Attorney General's Office, the State Department of Health (DOH), and OMIG.

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

Affected Persons should:

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

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

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

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

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

OHC is committed to ensuring that this Corporate Compliance Plan is properly implemented through routine monitoring and establishment of an annual Work Plan that will list audit priorities based on risk areas OHH has identified and those identified in published government work plans, such as the OMIG and OIG work plans, that are relevant to Oneida Health Hospital and its various provider entities.

The principal activities evaluated under the Work Plan will focus on the following risk areas identified in 18 NYCRR § 521-1.3(d),: 1. billings; 2. payments; 3. ordered services; 4. medical necessity; 5. quality of care; 6. governance; 7. mandatory reporting; 8. credentialing; 9. Contractor, subcontractor, agent or independent contract oversight; and 10. other risk areas that are or should with due diligence reasonably be identified by OHH through its organizational experience.

Annual Work Plan

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

The Corporate Compliance Officer and the Corporate Compliance Liaisons at OMP and OMS are also responsible for developing annual compliance work plans, which are submitted to the Corporate Compliance Committee for feedback (the "Practice Work Plans") using the same criteria outlined above as may be applicable to OMP and OMS operations.

Areas of concern can arise as a result of planned organization activities, such as areas of growth, process, people or system change. The collective 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 Corporate Compliance Committee meetings. The Work Plans should also be shared with the MPN President during the first quarter of the said year. In addition, the Board of Trustees will receive a quarterly update of Work Plan activities conducted.

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

Compliance Monitoring & Auditing

Oneida Health Hospital recognizes the importance of performing routine compliance audits, including self-evaluation of the compliance risk areas identified in 18 NYCRR § 521-1.3(d)), the published government work plans and the applicable OHH Work Plans.

Compliance monitoring and auditing procedures will be implemented that are designed to determine the accuracy and validity of the charging, coding and billing submitted to federal, state and private health care programs, contracts with Contractors, and to detect other instances of potential misconduct by employees and medical staff and others affiliated with OHH. Monitoring and auditing also play a role in evaluating OHH's compliance with applicable federal and state laws, rules and regulations, including New York and federal fraud, waste and abuse rules and Medicaid and Medicare requirements, and in determining the overall effectiveness of the Corporate Compliance Program. It will also include routine auditing and monitoring of OHH's operations and systems by internal and external auditors with expertise in state and federal Medicaid requirements and applicable laws, rules and regulations, or have expertise in the subject area of the audit, to determine the effectiveness of internal controls designed to prevent or detect errors, and to ensure compliance with internal policies and procedures, as well as applicable federal and state laws, rules and regulations, with a focus on those risk areas identified in 18 NYCRR 521-3(d) and the oversight of any other risk areas as may be 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 OHH Work Plan. This will include, but is not limited to, 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 and documentation provided by clinical ancillary, nursing and medical staff.

Self-evaluation of the areas identified in the OHH Work Plan and the Practice Work Plan will be accomplished through internal audits as directed by the Corporate Compliance Officer and/or Corporate Compliance Liaisons. Where appropriate, the Corporate Compliance Officer will arrange for external audits according to the risk areas identified above. Results of self-evaluations will be reported to the Corporate Compliance Officer, who will evaluate the potential for or actual non-compliance. The results of all internal and external audits, or audits conducted by the federal or state government, are also reviewed for risk areas that can be included Work Plans and/or the Compliance Program.

The Corporate Compliance Officer is primarily responsible for designing and 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 Corporate Compliance Officer is responsible for investigating and independently acting on incidents discovered by the audits, systemic errors, or reports of suspected noncompliance, and pursuing any resulting corrective action with internal departments, Contractors, and government agencies. The design, implementation and results of any internal or external audits are documented and communicated to the Corporate Compliance Committee and 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.

To ensure its effectiveness and determine whether any revisions or corrective actions are necessary, an annual review of the Compliance Program is performed.

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

XVI. SYSTEM FOR RESPONDING TO COMPLIANCE ISSUES

OHH will promptly respond to compliance-related concerns and complaints as they are raised, and will thoroughly investigate potential or actual non-compliance reported through the hotline or identified through its routine systems described above and promptly and thoroughly determine whether any corrective action is required. An investigation of a suspected violation typically will involve a review of relevant documentation and records, interviews with staff and others involved in the issue, and an analysis of applicable laws and regulations. The results of such investigations will be thoroughly documented and shared with the Corporate Compliance Committee and the Board on a confidential basis. Outside legal counsel will be consulted, as necessary. In addition, precautions will be taken to ensure that relevant documents to the investigation are not destroyed. Records of an investigation will include a description of the investigative process, copies of interview notes and key documents, a log of witnesses interviewed and documents reviewed, the results of the investigation, and any corrective action taken. The investigation may be conducted by the Corporate Compliance Officer, legal counsel or an outside expert.

Corrective Action

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

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

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

XVII. COMPLIANCE PROGRAM EFFECTIVENESS

The Corporate Compliance Plans and Work Plans shall be reviewed at least annually by the Corporate Compliance Committee and Corporate Compliance Officer to evaluate the effectiveness of the plan and to determine if changes and/or revisions or corrective actions are necessary. Reviews will include but not be limited to on-site visits, interviews with Affected Persons, and reviews of records. The design, implementation and results of the annual effectiveness review, and any corrective action implemented, will

be documented. The results of the annual evaluation shall be shared with the CEO, senior management, members of the Compliance Committee and the Board of Trustees for consideration.

Demonstrations of effectiveness will include but not be limited to:

1. Reports made to the Corporate Compliance Officer or the OMP/GPP and OMS Corporate Compliance Liaisons (either directly, through the hotline, or in report form), which indicate that Affected Persons are aware of the Corporate Compliance Program and the reporting systems and lines of communication 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 due to reported concerns.
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 meeting packets for its review.
5. Refunds have been made (and explained as applicable) to Medicare or Medicaid for overpayments received in error. Subsequently, refunding of overpayments discovered as part of an internal audit is typically a routine procedure at the conclusion of the internal audit. Alternatively, if overpayments are found on a case-by-case basis, those too will be refunded timely and appropriately.*
6. Completion of any self-assessment tool that is 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 overpayments. OHH follows 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.

OHH 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, OHH recognizes the importance of a solid charge master, as well as effective policies and procedures to govern accurate charging and crediting.

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

- Claiming reimbursement for services that have not been rendered,
- Filing duplicate claims,

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

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

The Fraud Enforcement and Recovery Act of 2009 (FERA) signed into law May 2009, implemented significant changes to the Federal False Claims Act by expanding the scope of the False Claims Act liability and makes it easier to prove fraud against the government 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

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 individual, organization, contractor or vendor who is listed by the OIG and/or the OMIG as debarred, excluded or otherwise ineligible for participation in Federal and State Health Care Programs. This prohibition is necessary to ensure 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 Affected Person charged with criminal offenses related to health care, must immediately be removed from direct responsibility for or involvement in any Federal and State Health Care Program until resolution occurs. If resolution results in suspension, conviction, debarment or exclusion of the Affected Person, the OHH Corporate Compliance Committee must immediately review the case and proceed with termination of employment or affiliation with OHH.

OHC shall terminate conditional employment or a conditional contract, or withdraw any offer of employment or affiliation of an individual or organization positively identified and determined to be excluded from participation in Federal and State Health Care Programs during the exclusion check process until such time that they are not on the list, or clear evidence has been provided showing that the matter(s) leading up to appearance of the exclusion list(s) have been resolved.

There is a process in place to ensure that all required exclusion screening occurs, including during the employment process and credentialing phase for providers. Additionally, on a monthly basis, a third-party vendor performs exclusion checks on behalf of OHH (e.g., Kchecks, and a vendor credentialing service "Green Solutions"). OHH also requires its Contractors to comply with these exclusion screening requirements. For any Contractor that is required to maintain an effective compliance program, the Corporate

Compliance Officer will consider the most efficient manner in which to ensure that required monthly screenings are conducted. Results of exclusion checks and related activities will be promptly shared with the Corporate Compliance Officer and other appropriate compliance personnel.

Please refer to Exclusion Checks Policy (CC 16-47) for additional instructions.

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

Oneida Health Hospital (OHH) takes health care fraud and abuse very seriously. It is our policy to provide information to all Affected Persons about:

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

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

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

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment to any employee;
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid;
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid[4].

A person can also be found liable under the false claims act who acts in reckless disregard of the truth or falsity of information.[5] 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;

[4] 31 U.S.C. section 3729 (a)
[5] 31 U.S.C. section 3729(b)

- 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 $13,506 and $27,018 per false claim[6], 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.

Please refer to the Health Care Waste, Fraud and Abuse Policy (CC 16-10) for additional information.

XXI. WHISTLEBLOWER PROTECTIONS

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

- Employees who choose to become a whistleblower have rights that are protected under the whistleblower protection laws.
- Federal and New York State law prohibit an employer from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. The employee is entitled to all relief necessary to make the employee whole[7].
- 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".

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[6] Amounts applicable to civil penalties assessed after December 22, 2022; penalty amounts are subject to adjustment each year.
[7] 31 U.S.C 3730 (h); State Finance Law §§ 187-194

- With the implementation of the Federal Enforcement and Recovery Act (FERA) of 2009, there are new procedural provisions that allow the government to intervene beyond the statute of limitations, in an existing qui tam suit by amending a complaint with new allegations.
- Whistleblowers also have protection under the NY Not-for-Profit Corporation Law § 715-B and NY Labor Law §§ 740 and 741.

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

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. All records demonstrating OHH has adopted, implemented and operated an effective compliance program shall be retained for a period of no less than six (6) years from the date of implementation, or any amendments thereto were made, and copies of such records shall be made available to the NYS Department of Health, OMIG, or MFCU upon request.

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 it continues to operate in a legal and ethical manner. Without involvement and engagement, the Corporate Compliance Program cannot succeed. As such, all Affected Persons, as applicable, are responsible for:

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

Compliance Reporting Form

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

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

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

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

EDM (01209) 9/08 Compliance Reporting Form Staff

: 06/23

Revised 09/2008, 9/2009, 12/2012, 3/12/2013, 02/19/15, 1/31/18, 5/18, 4/23

SCHEDULE 1

Oneida Health Divisions

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

- Oneida Health Hospital, including:
  - OHH Acute Care Facility;
  - OHH Extended Care Facility, Rehabilitation and Extended Care;
  - OHH Article 28 Health Centers, including:
    - Chittenango Family Care
    - Canastota Lenox Family Care
    - Verona Family Care
    - Wound Care and Hyperbaric Medicine Center
    - Oneida Health Cardiology Specialists
    - Oneida Health Cancer Care, Radiation & Medical Oncology
    - Alice Gorman Imaging Center
    - Sleep Center
    - Outpatient Rehabilitation Services
    - Oneida Health Draw Stations, Camden, Canastota, Chittenango, & Seneca.

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

- Oneida Medical Services, PLLC, Women's Care
- Genesee Physician Practice, PLLC, (Anesthesia); NAPA Anesthesia (contracted)

Schedule 2

Oneida Health
Corporate Compliance Committee Charter
CHARTER

I. PURPOSE

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

II. COMPOSITION

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

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

III. MEETINGS

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

IV. RESPONSIBILITIES AND DUTIES

The Committee's responsibilities and duties shall include:

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

  - Review and discuss HIPAA privacy issues & activities;
  - Review and discuss HIPAA Security issues & activities;
  - Review and discuss CC Code of Conduct activities;
  - Review and discuss 340B Program issues & activities; and
  - Review and discuss EMTALA issues;
- Review and make recommendations on compliance auditing and monitoring activities and coordinate with the Corporate Compliance Officer to ensure required internal and external audits, as appropriate, are conducted;
- Receive and discuss updates and status on rules and regulations that govern the Hospital and affiliates;
- Review and discuss any provider compliance issues;
- Review and approve the annual compliance work plan and resulting activity while monitoring OIG and OMIG work plans and focus areas;
- Reviewing and updating, as necessary, the Compliance Committee Charter annually and maintaining minutes demonstrating the annual review, including if no changes to the Charter are necessary;
- Advocating that the Corporate Compliance Officer has the necessary funding, resources and staffing, as appropriate, to adequately perform compliance-related functions;
- Ensuring effective risk identification and remedial actions, including refunding of overpayments, are implemented;
- Providing assistance to the Corporate Compliance Officer in fulfilling his/her oversight responsibility for the Hospital's Compliance Program, policies and procedures; and
- Performing any other duties as directed by the Board of Trustees of OHH.

Approved and adopted by the Board of Trustees:

____ __________________

Chairman, Board of Trustees **Date**

____ __________________

Corporate Compliance Officer **Date**

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