COMPLIANCE PLAN

STONY BROOK PEDIATRICS' HEALTHCARE COMPLIANCE PLAN

Welcome to Stony Brook Pediatrics! For over 30 years our offices in Geneseo and Dansville have focused on providing exceptional care for children of all ages in Livingston County and the surrounding areas. Here at Stony Brook Pediatrics, we believe in the concept of the "Medical Home," while it is not a physical location, it is an important concept in preventative care. The American Academy of Pediatrics describes the "Medical Home" as "a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

Stony Brook Pediatrics strives to create a welcoming environment that fosters appreciation of the cultural diversity of our patients and helps meet the communication needs of our patients so they can understand the care that is received, participate effectively in their care, and make informed decisions.

Stony Brook Pediatrics, hereinafter SBP or Stony Brook where appropriate, has established this healthcare compliance plan (the "Plan") to ensure that it complies with anti-kickback provisions of the Federal Medicare and Medicaid Fraud and Abuse Statute (the "Anti-Kickback Statute"), the Federal Ethics in Patient Referrals Act (the "Stark Law"), the Federal False Claims Act (the "False Claims Act") and the Health Data Electronic Transactions and Privacy Standards from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). SBP shall adopt and comply with this plan. All previous compliance plans shall be considered revoked. Compliance with the above-mentioned statutes and regulations is important because the failure to abide by the same may be a criminal violation and can lead to serious financial and/or criminal liability for individuals and organizations.

The compliance efforts of SBP are designed to establish a culture within the practice that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, and federal, state, and private payor health care program requirements, as well as SBP's ethical and business policies. These efforts will address regulations regarding fraud and abuse and the standards for electronic transactions and medical information privacy and security.

SBP is committed to conducting all of its business in compliance with ethical standards and all applicable laws, rules, and regulations. The Standards of Conduct and Compliance Plan does not represent any change from SBP's prior or current practices, but, rather, is a compilation of those practices to guide all employees.

This Compliance Plan is not intended to be a comprehensive explanation of the regulations regarding fraud and abuse and medical information privacy, nor will it provide answers to every possible issue that may arise under these regulations. Rather, it is intended to sensitize SBP to potential problems that may arise under the regulations regarding fraud and abuse and medical information privacy so that advice can be sought if such issues arise. SBP expects full compliance with the guidelines set forth in this Plan and encourages its members and employees to seek any further information or clarification necessary prior to engaging in any potentially sensitive actions or activities.

This Compliance Plan is intended to apply to all of SBP's activities. It is applicable to any affiliated providers, employees, management and governing body and other committee members. If an employee has any question about the application of this Compliance Plan, they should raise their questions to the Compliance Contact, his or her supervisor, a member of the Compliance Committee, and if absolutely necessary, the Medical Board.

This Plan is divided into two main sections: (1) an overview of the Anti-Kickback Statute, the Stark Law; the False Claims Act, and HIPAA; and (2) the specific Compliance Plan. While all owners and employees of SBP should read both sections, it is particularly important for all owners and employees to understand what standards of behavior the compliance guidelines create for them. Accordingly, it is mandatory for each owner and employee to review the Plan. Following the Plan is an acknowledgment form that each owner and employee must complete to signify that they understand the requirements of the Plan.

SECTION 1

SUMMARY OF THE ANTI-KICKBACK STATUTE, THE STARK LAW, THE FALSE CLAIMS ACT AND THE HIPAA ELECTRONIC TRANSACTION AND PRIVACY STANDARDS

The Anti-Kickback Statute

The Anti-Kickback Statute prohibits the *knowing and willful* solicitation, receipt, offer or payment of "any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind" in return for or to induce the referral, arrangement or recommendation of Medicare or Medicaid business. 42 U.S.C. § 1320a-7b(b). Violation of the Anti-Kickback Statute is a felony and may result in a fine of up to $25,000, imprisonment for up to 5 years, or both. In addition, the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) is empowered to suspend or exclude providers or suppliers from participation in the Medicare or Medicaid Programs if it determines, in its discretion, that a provider or supplier has violated the Anti-Kickback Statute. 42 U.S.C. § 1320a-7b(b)(7).

COURTS HAVE INTERPRETED THE ANTI-KICKBACK STATUTE VERY BROADLY, FINDING THAT REMUNERATION CAN INCLUDE "ANYTHING OF VALUE IN ANY FORM WHATSOEVER." COURTS ALSO HAVE FOUND THAT REMUNERATION IS ILLEGAL IF ANY PORTION OF THE REMUNERATION IS INTENDED TO INDUCE REFERRALS.

Safe Harbor Provisions are found in 42 C.F.R. §1001.952. The following payment practices shall not be treated as a criminal offense under §1128B of the Act and shall not serve as the basis for an exclusion:

- 42 C.F.R. §1001.952(a) Investment Interests
- 42 C.F.R. §1001.952(b) Space Rental
- 42 C.F.R. §1001.952(c) Equipment Rental
- 42 C.F.R. §1001.952(d) Personal Services, Management Contracts, Outcome-Based Payment Arrangements
- 42 C.F.R. §1001.952(e) Sale of Practice
- 42 C.F.R. §1001.952(f) Referral Services
- 42 C.F.R. §1001.952(g) Warranties
- 42 C.F.R. §1001.952(h) Discounts
- 42 C.F.R. §1001.952(i) Employees
- 42 C.F.R. §1001.952(j) Group Purchasing Organizations

- 42 C.F.R. §1001.952(k) Waiver of Beneficiary Copayment, Coinsurance, and Deductible Amounts
- 42 CFR §1001.952(L) Increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans.
- 42 CFR §1001.952(m) Price Reductions Offered to Health Plans
- 42 CFR §1001.952(n) Practitioner Recruitment
- 42 CFR §1001.952 (o) Obstetrical Malpractice Insurance Subsidies
- 42 CFR §1001.952 (p) Investments in Group Practices
- 42 CFR §1001.952(q) Cooperative Hospital Service Organizations
- 42 CFR §1001.952(r) Ambulatory Surgical Centers
- 42 CFR §1001.952 (s) Referral Arrangements for Specialty Services
- 42 CFR §1001.952(t) Price Reductions Offered to Eligible Managed Care Organizations
- 42 CFR §1001.952 (u) Price Reductions Offered by Contractors with Substantial Financial Risk to Managed Care Organizations
- 42 CFR §1001.952(v) Ambulance Replenishing
- 42 CFR §1001.952(w) Health Centers
- 42 CFR §1001.952(x) Electronic Prescribing Items and Services
- 42 CFR §1001.952(y) Electronic Health Records, Items, and Services
- 42 CFR §1001.952 (z) Federally Qualified Health Centers and Medicare Advantage Organizations
- 42 CFR §1001.952 (aa) Medicare Coverage Gap Discount Program
- 42 CFR §1001.952 (bb) Local Transportation
- 42 CFR §1001.952(cc) Point-of-Sale Reductions in Price for Prescription Pharmaceutical Products
- 42 CFR §1001.952 (dd) PBM Service Fees
- 42 CFR §1001.952 (ee) Care Coordination Arrangements to Improve Quality, Health Outcomes, and Efficiency
- 42 CFR §1001.952 (ff) Value-Based Arrangements with Substantial Downside Financial Risk
- 42 CFR §1001.952 (gg) Value-Based Arrangements with Full Financial Risk
- 42 CFR §1001.952(hh) Arrangements for Patient Engagement and Support to Improve Quality, Health Outcomes, and Efficiency
- 42 CFR §1001.952(ii) CMS-Sponsored model arrangements and CMS-Sponsored Model Patient Incentives
- 42 CFR §1001.952 (jj) Cybersecurity, Technology, and Related Services

- 42 CFR §1001.952 (kk) ACO Beneficiary Incentive Program

Arrangements that satisfy all of the requirements of a regulatory safe harbor are immune from both criminal prosecution and administrative enforcement by the OIG. Arrangements that do not qualify under a safe harbor, however, are not necessarily illegal. Such arrangements will be scrutinized under the Anti-Kickback Statute to determine whether, through the particular arrangement, remuneration was given or offered as an inducement for referrals. If it is determined that remuneration was, in fact, given or offered to induce referrals, the arrangement will violate the Anti-Kickback Statute.

SBP's Compliance Officer, together with SBP's Governing Body, will attempt to structure all relationships such that they do not violate the Anti-Kickback Statute.

The Centers for Medicare & Medicaid Services (CMS) (formerly known as the Health Care Financing Administration) has implemented a safe harbor applicable only to Medicare-certified HCOs (HCO Safe Harbor). 64 Fed. Reg. 63518 (1999) (to be codified at 42 C.F.R. pt. 1001). HCO Safe Harbor provides for four categories. The applicable category depends upon the composition of a particular surgery center's investors, as follows:

- Surgeon-Owned HCOs
- Single-Specialty HCOs
- Multi-Specialty HCOs
- Physician/Hospital HCOs

To comply with a Safe Harbor, an HCO must meet a number of different requirements. These requirements are discussed in Section (q).

The Stark Law

The Stark Law prohibits, with certain statutory exceptions, a physician who has an ownership interest in, or a compensation arrangement with, an entity from referring patients to that entity for the provision of "Designated Health Services" if payment for those services may be made by Medicare or Medicaid. 42 U.S.C. § 1395(nn). The Stark Law provides federal regulatory bodies authority to publish regulations to clarify the statute and/or impose additional requirements to carry out the intent of the statute.

The Stark Law prohibits physicians from referring a patient for Designated Health Services to an entity with which the physician has a "financial relationship" and for which payment may be made by Medicare or Medicaid.

Designated Health Services include:

- Clinical laboratory services;
- Radiology services and certain other imaging services;
- Durable medical equipment and supplies;
- Radiation therapy services and supplies;
- Physical therapy services;
- Occupational therapy services;

- Speech-language pathology services;
- Parental and enteral nutrients, equipment, and supplies;
- Outpatient prescription drugs;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Inpatient and outpatient hospital services;

Physicians may only own interests in or have financial relationships with providers or entities that provide Designated Health Services if the relationships or operations are structured to qualify for at least one of the statutory exceptions to the Stark law.

Exceptions to the Stark Law (42 CFR §411.357) include but are not limited to: rental of office space, rental of equipment, bona fide employment relationships, personal service relationships, physician recruitment, isolated transactions, certain arrangements with hospitals, group practice arrangements with a hospital, payments by a physician, charitable donations by a physician, non-monetary compensation, fair market value compensation, medical staff incidental benefits, risk-sharing arrangements, and compliance training as long as they are:

a. In writing and signed by the lessor and lessee;
b. For a 1-year term or longer;
c. The rented space is reasonable and necessary for business purposes;
d. Rent, fees, and compensation are based on fair market value;
e. Rent, fees, compensation, and benefits are not based on referrals or other business generated;

Referrals from physician owners of an HCO to the HCO itself would not implicate the Stark Law, as surgical procedures performed in an HCO do not qualify as designated health services (however, referrals from physician owners of an HCO to HCO may, in fact, implicate state self-referral laws). Further, CMS has clarified that it does not intend for the Stark laws to cover services provided by an HCO that are also reimbursed by Medicare under HCO group rate. Thus, as long as the procedures and services are not separately billable to the Medicare or Medicaid programs other than through SBP payment rates; HCOs are not prohibited under the Stark Law from providing outpatient surgical services and related services. In contrast, the Stark Law will prohibit the provision by an HCO of separately billable labs, prescription drugs, and physical therapy services.

SBP must be aware that Medicare and Medicaid referrals to other parties for Designated Health Services may be prohibited under Stark, pursuant to further regulations by the OIG. For Stark purposes, a referral includes a referral to the physician who orders or provides the services. As regulations are promulgated for Stark, the Chief Compliance Officer of SBP will educate employees regarding its applicability to SBP operations.

The False Claims Act

Individuals or entities that knowingly file fraudulent or false claims that are payable by the Medicare program are subject to both criminal and civil liability. Under the Criminal False Claims Act, individuals or entities that knowingly file such claims may receive a fine of up to $10,000, imprisonment of up to five years, or both. 18 U.S.C. § 287. Under the Civil False Claims Act, an individual or entity that knowingly files such claims is liable to the United States Government for a civil penalty of not less than $10,781 and not more than $21,562, plus three times the amount of damages which the Government sustained for each illegal claim filed. 31 U.S.C. § 3729. Moreover, private persons may bring civil actions against individuals or entities for violation of the Civil False Claims Act on behalf of the Government, and they may share in any proceeds ultimately recovered as a result of the suit.

Individuals or entities that knowingly make or cause to be made a false statement or misrepresentation on any claim that is submitted for payment by the Medicare or Medicaid program may also be subject to civil and criminal liability under the Medicare and Medicaid Patient and Program Protection Act. 42 U.S.C. § 1320a-7a. The penalty for violation of this Act is up to five years in prison, and/or a $25,000 fine.

SBP will pay particular attention to whether the following activities are taking place within the practice, as such activities are those most frequently found to violate the False Claims Acts:

- Up-coding;
- billing for services not rendered;
- filing of false cost reports;
- double billing;

Up-coding is the process of inflating bills by using diagnosis billing codes that suggest a more expensive illness or treatment.

Double billing occurs by charging more than once for the same goods or service.

As this list is not exhaustive, SBP should be aware of any activity in which an individual or entity may be filing claims it knows to be false or fraudulent to either the Medicare or Medicaid program.

Following the passage of the Affordable Care Act in 2010, providers also now have an affirmative obligation to repay identified overpayments to government payors or risk the retention of those overpayments also being considered “reverse” false claims.

HIPAA Electronic and Privacy Standards

The Health Insurance Portability and Accountability Act, commonly referenced as HIPAA, was enacted in 1996 and brought sweeping changes to several areas of health care activity. The primary intent of HIPAA was to improve the portability and continuity of health insurance coverage to protect workers who lose or change their jobs. In addition, however, HIPAA included significant changes to the statutory scheme of health care fraud and abuse enforcement and provisions to encourage the establishment of medical savings accounts. Finally, HIPAA contained provisions to simplify the administration of health insurance by standardizing the electronic

transmission of certain administrative and financial transactions and to protect the privacy of individually identifiable health information.

HHS issued regulations to protect the privacy of individually identifiable health information that is transmitted electronically, maintained electronically, or transmitted or maintained in any other form or medium (including oral statements). The final HIPAA regulations were published on August 14, 2002. Additionally, rule makings have significantly expanded the scope of HIPAA since its original rules were issued in 2002. Most recently, a very comprehensive rule making, referred to as the HIPAA Omnibus Rule, greatly expanded upon the current body of HIPAA regulations and extended liability for HIPAA non-compliance to vendors of healthcare providers who maintain, store, or transmit electronic protected health information on a healthcare provider's behalf (referred to as "Business Associates").

Generally, all individual or group health plans, including managed care organizations and ERISA plans, all government plans, including Medicare and Medicaid programs, all health care clearing houses, and any health care providers choosing to transmit certain health information electronically are required to use the standards by the implementation date. These entities are considered "Covered Entities" under HIPAA.

Under HIPAA, HHS issued a rule to protect the privacy of medical records that are transmitted or maintained electronically, and the paper print outs from these records created by health plans, providers, hospitals and health care clearing houses. The privacy rule only protects individually identifiable information that has been maintained or transmitted in electronic form. Electronic form includes information on magnetic tape, disk, or CD as well as information transmitted via Internet, private networks, extranet, and leased or dial up line. Information that is covered by the rule by virtue of its being stored or transmitted electronically is also protected even after it is printed, discussed orally or otherwise modified in format. The original paper version of the information also becomes protected after the information is transmitted or stored electronically.

Covered Entities may not avoid compliance by contracting out administrative services related to standardized electronic transactions. The regulations provide that a Covered Entity that uses a Business Associate to conduct all or part of a standard transaction must require the Business Associate to not only comply with all applicable requirements, but also require any agent or subcontractor to comply with all specific requirements.

The security standards under HIPAA and the privacy regulations both aim to protect the confidentiality and the integrity of health data as well as ensure that the information is available in the delivery of health care services. The focus of the standards is different though, in that the privacy standards target the rights and expectations of patients with respect to how their private medical information is handled by providers and organizations. The security standards on the other hand, provide guidance to organizations and providers on how to protect the integrity and confidentiality of medical information.

Covered entities must take measures to limit the external and internal disclosures of health information to the minimum amount of health information necessary to accomplish the purpose for which the information is used or disclosed. This minimum necessary standard requires covered entities to apply an element of good judgment and

discretion in responding to requests for health information and to train staff members involved in responding to these requests accordingly. Computer systems and software may also need to be reconfigured to insert tighter access features, so that employees can only access the portion of patient records that is necessary to allow them to perform their duties.

The rule also contains provisions that give individuals an organized process for accessing and controlling their health information. Covered entities must provide patients with a notice which explains their privacy practices and informs the patients of their rights under the covered entity's privacy policies and the privacy regulations. Covered entities must obtain a patient's acknowledgement that he or she has read and understands the notice of privacy practices before they may use and disclose protected health information for purposes of treatment, payment and health care operations. Covered entities must also obtain an authorization from an individual before using or disclosing protected health information for other purposes. The regulations outline several requirements for obtaining authorization to disclose health information to ensure that the individual's authorization is voluntary. Individuals have the right under the regulations to inspect and copy their health records and request amendment or corrections of inaccurate information. Covered entities are required under the regulations to keep a history of most disclosures for purposes other than treatment, payment and health care operations and make this history accessible to patients.

HHS may impose sanctions for failure to comply with requirements of the rule, including fining entities up to $25,000 per year for each civil violation. In addition, HHS may impose criminal penalties for certain wrongful disclosures. The criminal penalties vary depending on whether the offense is committed under false pretenses or with the intent to sell the information or use it for personal gain. Individuals do not have a private right of action under regulations. In addition, the regulations create a system allowing individuals to make complaints to HHS about potential violations of the regulations and require covered entities to develop a process to review complaints about such violations.

It is SBP's commitment to be proactive and to incorporate these standards in its activities in the handling of each patient's health data information.

SECTION 2

THE COMPLIANCE PLAN & COMPLIANCE GUIDELINES

(a) Chief Compliance Officer

Stony Brook Pediatrics' medical board ("Governing Body") shall appoint a Chief Compliance Officer or a Compliance Contact. The Chief Compliance Officer or Contact will report to the Corporate Compliance Committee and oversee the Compliance Program. The Chief Compliance Officer or Contact will be responsible for:

- Developing compliance policies and standards;
- Overseeing and monitoring SBP's compliance activities;
- Achieving and maintaining compliance;
- Ensuring that all policies are kept current and followed by all employees;

- Distributing the policies that are readily understandable by all employees (including translated into other languages, if necessary) to appropriate individuals;
- Appointing employees to serve in various roles and to complete any tasks as needed to promote and conform to the compliance program;
- Report directly to members of the Compliance Committee;
- Participate in investigations of compliance violations;
- Participate and conduct annual audits;
- Monitor the anonymous compliance email and;
- Performing other functions as specified throughout this Plan.

Potential Anti-Kickback, Stark, False Claims, and Electronic Transaction and Privacy Standards issues, problems or questions will be addressed to the Chief Compliance Officer or contact.

(b) Written Policies and Procedures

The Chief Compliance Officer or contact will develop and distribute written compliance policies regarding Anti-Kickback, Stark, False Claims, or HIPAA privacy issues that address specific areas of potential violations of such statutes and regulations, such as billing, contracting, marketing and claims processing.

The compliance policies shall be distributed to all individuals who are affected by the specific policy at issue. The Chief Compliance Officer or contact should also develop a clear system to retain these policies so that they are easily retrieved for reference.

(c) Standards of Conduct for Employees and of Stony Brook Pediatrics

The following list contains standards of conduct that apply to all employees of Stony Brook Pediatrics and delineates SBP's policies with regard to legal compliance. These standards will be made available to all employees of SBP.

Employees of SBP cannot offer any remuneration, which means any kind of payment, including kickbacks, bribes or rebates, either in cash or in kind, in any manner or form to any physicians or other party in order to induce the referrals of any health care business, patients, or other items or services to SBP. Additionally, all employees and owners shall be given, and shall abide by, SBP's written Code of Conduct.

All employees shall perform their duties in good faith and to the best of their ability and refrain from any illegal conduct.

- No employee, physician, or officer of SBP shall obtain any improper personal benefit by virtue of his or her employment or relationship with SBP.
- If any employee of SBP becomes aware of any remuneration offered to physicians, such conduct must be reported immediately to the Chief Compliance Officer/Contact or reported anonymously to the compliance violation email.
- Before SBP enters into any material agreement with any physicians or other party that may refer business to SBP, the relationship should be approved by the Chief Compliance Officer/Contact and the Compliance Committee. This

includes all leases, purchases, or orders that are entered into with and approved by physicians who refer patients. Any employee or medical staff member shall disclose to the Chief Compliance Officer/Contact any financial interest or ownership interest or any other relationship that they (or a member of their immediate family) have with SBP's customers, vendors, or competitors.

- SBP shall periodically provide examples of relationships with physicians that can cause Fraud and Abuse concerns. If an employee of SBP becomes aware of or discovers any of these relationships, they must report such information to the Chief Compliance Officer/Contact.
- If an employee becomes aware of or discovers any lease, purchase agreement, or order for goods or services for any amount other than fair market value, the employee must call the Chief Compliance Officer/Contact.
- If any payments are made to a physician to reduce or limit services offered to a Medicare or State assistance patient under the physician's care, they must be reported and approved.
- SBP and the physicians, except to the extent of the ASC Safe Harbor relevant to any surgery center owned by any physician or SBP, will not be required or expected to refer Medicare and/or Medicaid business to their business affiliates.
- Any waiver of Medicare Part B or other deductibles or copayments must be reported to and approved by SBP. Routine waivers of deductibles or copayments for Medicare and Medicaid patients will not be permitted.
- Employees involved in billing functions cannot bill any claims for any amount other than in accord with SBP's usual and customary fee for the particular service or procedure being provided or according to SBP policies or SBP contracts with other health care programs.
- If employees know of or discover any claims billed for an amount in excess of permitted rates, it must be reported to the Chief Compliance Officer/Contact. This includes any double billing or balance billing.
- If an employee of SBP becomes aware of or discovers any medical claims or other service claims that are false or that are medically unnecessary services, the claim must be reported to the Chief Compliance Officer/Contact.
- Claims can only be submitted to federally funded health care programs or to other payors for services and procedures that are medically necessary.
- Employees should not rely on previous service information to determine the information necessary for billing. The ordering physician must provide the information at the time of service.
- Employees of SBP shall attend periodic training and educational programs regarding Anti-Kickback, Stark, False Claims, and HIPAA issues.
- Employees and physicians will not accept any substantial and excessive gratuities or gifts that are not approved by the Medical Board and Compliance Committee in any form.

- Employees will not use confidential or proprietary SBP information for their own personal benefit or for the benefit of any other person or entity, while employed at SBP, or at any time thereafter.
- Employees will not destroy or alter information or documents in anticipation of, or in response to, a request for documents by any applicable government agency or from the court of competent jurisdiction. Destruction of any pertinent information in anticipation of a request for documents is subject to criminal liability and termination of employment with SBP.
- Employees will not disclose confidential medical information pertaining to SBP's patients without the express written consent of the patient and in accordance with applicable law and SBP's applicable policies and procedures.

(d) Educational and Training Programs

There will be periodic compliance and ethical educational and training programs offered to all employees of SBP, but especially to personnel involved in billing, sales, leasing, contracting, staffing, marketing, and test ordering. These programs will be designed to:

- Teach employees what procedures are not allowed under the Anti-Kickback Statute, the Stark Law, the False Claims Act, HIPAA, and what procedures should be used under the Plan.
- Emphasize SBP's commitment to compliance with all laws, regulations, and guidelines of Federal and State programs.
- Reinforce the fact that strict compliance with the law and SBP's policies is a condition of employment.

Employees will be informed that failure to comply may result in disciplinary action, including termination.

Employees will be encouraged to attend any continuing education programs offered for their occupation, as such programs will help ensure a knowledgeable and more productive staff. Any continuing education programs in the area of corporate compliance will be paid for by SBP.

Specifically, training of sales and marketing personnel will highlight the prohibition against offering remuneration in return for referrals, and the fact that SBP will take appropriate disciplinary action up to and including termination for violations of the laws or failure to report a potential violation by another employee, supervisor, or outside contractor or provider.

Finally, SBP will post in common work areas and other prominent places accessible to all employees a notice clearly reminding employees of SBP's commitment to compliance with all laws and regulations. These postings will be updated regularly with new information to ensure the utmost compliance with the Plan.

(e) Auditing and Monitoring

Because the OIG will be critical of compliance plans that exist on paper but are not earnestly implemented or enforced, the Chief Compliance Officer/Contact shall monitor the implementation of this plan and report regularly to the Medical Board and the Compliance Committee. One such monitoring technique will be regular, periodic

compliance audits to study legal and regulatory compliance. These audits will be designed to ensure compliance with SBP's compliance plan and policies, and all Federal and State laws and will also address issues related to contracts, competition, marketing materials, coding and billing, electronic transactions, medical data privacy and security, reporting, and record keeping. The audit and monitoring process may include:

- On-site visits;
- Interviews with personnel involved in management, operations, billing, sales, marketing, referrals, and other related activities;
- Review contracts with and compliance plans of "business associates or partners";
- Review of materials and documentation used by SBP;
- Billing and coding analysis and audits.

The audit reports should specifically identify areas where corrective actions are needed. The audit reports will be thoroughly reviewed and any corrective measures necessary will be made. Follow-up audits will be conducted to ensure that the corrective measures were implemented and remedied the situation.

(f) Disciplinary Actions

Strict compliance with these policies and requirements is a condition of employment. SBP will develop a policy regarding the appropriate disciplinary actions for misconduct, violating this compliance plan, or violating the Anti-Kickback Statute, the Stark Law, or False Claims Act, or State anti-kickback, self-referral, or False Claims Act, or the HIPAA privacy and security requirements.

(g) Investigation

The Chief Compliance Officer/Contact and the Compliance Committee, with legal counsel as needed, will promptly investigate any potential violations or misconduct to determine whether a material violation has in fact occurred, and if so, will take steps to rectify it, report it to the government, if necessary, and make any appropriate payments to the government. Depending on the nature of the allegations, the investigations will include interviews and review of relevant documents, such as submitted claims, procedure and service order forms, and medical reports. If necessary, the Chief Compliance Officer/Contact will engage outside auditors or counsel to assist in the investigation.

If a material violation has occurred, the Compliance Committee and the Medical Board shall hold an ad hoc tribunal to determine the appropriate disciplinary action for the violation.

If the integrity of the investigation may be at stake because of the presence of employee(s) under investigation, the employee(s) allegedly involved in the misconduct can be removed from his or her current work activity until the investigation is completed. In addition, the Chief Compliance Officer/Contact will take steps to prevent the destruction of documents or other evidence relevant to the investigation. Once an investigation is completed, if disciplinary action is warranted, it will be immediate.

(h) Evaluation of Supervisors and Managers

Promotion of and adherence to this compliance plan will be an element in evaluating the performance of managers and supervisors. Because of this requirement, managers, and supervisors, along with other employees, will be periodically trained in new compliance policies and procedures.

In addition, managers and supervisors will be responsible for:

- Discussing with all supervised employees the compliance policies and legal requirements applicable to their function(s).
- Informing all supervised personnel that strict compliance with these policies and requirements is a condition of employment.
- Disclosing to all supervised personnel that SBP will take disciplinary action up to and including termination for violation of these policies or requirements.

Supervisors and managers failing to adequately instruct their subordinates or failing to detect non-compliance with applicable policies and legal requirements, where reasonable diligence on the part of the supervisor or manager would have led to the discovery of any problems or violations and given SBP the opportunity to correct them earlier, will be considered during evaluations.

(i) Non-Employment or Retention of Sanctioned Individuals

Individuals who have been convicted of a criminal offense related to health care or who are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federally funded health care programs will not be employed by, or have an ownership interest in SBP.

Current employees who are charged with criminal offenses related to health care or proposed for exclusion or debarment should be removed from direct responsibility for, or involvement in any federally funded health care program until resolution of such criminal charges or proposed debarment or exclusion. If resolution results in conviction, debarment, or exclusion of the individual, SBP will terminate its employment of that individual.

(j) Communication Regarding Anti-Kickback, Stark, False or HIPAA Claims Issues

Employees must report all instances of Anti-Kickback, Stark, False Claims, or HIPAA violations to the Chief Compliance Officer/Contact or to whomever is appointed by him or her to handle such cases.

Employees are encouraged to ask about any questionable or confusing issues. Employees may bring any information and questions without retribution and with complete anonymity.

An anonymous email will be regularly monitored by the Chief Compliance Officer/Contact in order to answer questions, address confusing issues, and allow SBP's employees a safe environment to report any suspected violations.

EMPLOYEES WILL NOT FACE ANY PENALTIES OR OTHER FORMS OF RETRIBUTION WHEN THEY MAKE ANY SUCH REPORTS TO THE CHIEF COMPLIANCE OFFICER/CONTACT IN GOOD FAITH.

Any matters reported to the Chief Compliance Officer/Contact that suggest violations of compliance policies or legal requirements should be investigated immediately to determine their veracity.

(k) Record Creation and Retention

All records required either by federal or state law or by this compliance plan will be appropriately created and maintained. Where patient confidentiality will not be compromised, reports summarizing the records should be created and maintained. If there is any question whether patient confidentiality will be compromised, legal counsel should be consulted.

(l) Marketing

All marketing done on behalf of SBP should be honest, straightforward, fully informative, and non-deceptive. Physicians and other providers should fully understand the services offered by SBP and the financial consequences for Medicare, as well as other payors, for the services provided.

NO REMUNERATION WILL BE GIVEN IN ORDER TO INDUCE A REFERRAL TO STONY BROOK PEDIATRICS.

(m) Waiver of Copayments and Deductibles

In the Medicare, Medicaid, and governmental contexts, co-payments and deductibles should not be waived or discounted except in accordance with an indigent care policy. If copayments or deductibles are to be waived or discounted, they must be waived or discounted in accordance with SBP's policies regarding same.

It is important that SBP does not engage in activity that could be construed as advertising or marketing, its intent to waive or reduce co-payments. In fact, SBP should avoid terms such as "insurance only" in discussions with patients. All co-payments, waivers and discounts thereof should be carefully considered on a case-by-case basis. When SBP engages in a regular set of discounting practices, it may subject itself to a greater risk of potential lawsuits from insurance companies and regulators.

(n) Medical Necessity Requirement

SBP will only bill federally funded health care programs for medically necessary services and procedures. Documentation will be created and stored that supports the medical necessity of a service or procedure.

Because it is ultimately the physician's responsibility to order the medically necessary service or procedure, SBP will take steps to ensure that the physicians understand Medicare's definition of medical necessity and only order those services or procedures that are medically necessary. Specifically, SBP will:

- Tell physicians which services or procedures are covered by Medicare.
- Provide physicians with written notices annually, or more often, if required, that set forth SBP's medical necessity policy, the billing codes the provider should use to bill Medicare for services and procedures, and a description of how the provider will bill Medicare for each service or procedure.

In addition, the Compliance Officer/Contact will standardize physician order forms and the forms will require physicians to document the need for each service or

procedure ordered by inserting the appropriate code for each such service or procedure. These forms should also make clear which services and procedures are covered and include a statement that only medically necessary services and procedures should be ordered.

The physicians will also be required to sign physician acknowledgment forms annually in which the physicians affirm such items as the physician's understanding that Medicare will only pay for a medically necessary service or procedure.

(o) Billing

SBP is committed to prompt, complete, and accurate billing of all services provided to patients for payment by patients, government agencies, or other third-party payers. Billing shall be made only for services provided, pursuant to all terms and conditions specified by the government or private payor, and consistent with industry practices. No false or misleading entries shall be made or submitted on any bills or claim forms, and no employee shall engage in any arrangement, or participate in such an arrangement at the direction of another employee (including any officer or supervisor of SBP) that results in such prohibited acts. Any false statement on any bill shall subject the employee to disciplinary action by SBP, including possible termination of employment. Claims will be submitted only when appropriate documentation supports the claim for medical necessity ("reasonable and necessary services") and only when such documentation is maintained and available for audit and review. SBP will provide the coding and billing staff with the necessary documentation and references for accurate code assignment.

It is SBP's standard to provide the highest quality of health care data submission as evidenced by its accuracy, reliability, timeliness, and validity as regulated by the Health Information Privacy Act.

False claims and billing fraud may take a variety of different forms, including, but not limited to, false statements supporting claims for payments, misrepresentation of material facts, concealment of material facts, or theft of benefits or payments from the party who is entitled to receive it. Although not an exhaustive list, SBP and its employees shall specifically refrain from engaging in the following billing practices:

- Billing for services not rendered, for false diagnoses, or for unnecessary services;
- Providing medically unnecessary services;
- Fraudulently changing procedure codes, (unbundling and up-coding);
- Duplicate billing;
- Credit balances—failure to refund balances in accordance with SBP's policies;
- Brand-name billing for generic drugs;
- Billing for services provided by unlicensed practitioners;
- Excessive payments for medical directorships, free or below market rents or fees for administrative services and interest-free loans.

SBP will install a system by which to ensure that all claims submitted to Medicare or other federally funded health care programs are accurate and correctly identify the services or procedures ordered and performed.

As stated in Section N, part of this system will include standardized billing and physician forms. When billing Medicare, the code that most accurately describes the service or procedure must be used.

Intentional up-coding results in potentially false claims under Medicare and thus, must not be done. If there is a question as to what the appropriate code is, the Chief Compliance Officer /Contact or their designated assistant should be consulted.

To avoid miscoding billing forms, SBP will only use the information provided by the physician at the time of or specific to the service or procedure and will not:

- Use information provided by the physician from earlier dates of service;
- Use cheat sheets that provide information for what has resulted in reimbursement in the past, will not use computer programs that automatically insert codes without receipt of information from the physician;
- Make up information for claims submission purposes.

In addition, SBP will only bill for those services and procedures that were actually performed. If there is a question as to what was performed, the physician and other involved parties will be contacted before a service or procedure is billed.

THE SUBMISSION OF CLAIMS FOR SERVICES OR PROCEDURES THAT WERE NOT ORDERED OR WERE NOT PERFORMED ARE POTENTIAL FALSE CLAIMS ACCORDING TO THE OIG.

The Compliance Officer/Contact will monitor SBP's billing to ensure that SBP is not providing ancillary services for Medicare and other Federal health program beneficiaries which are not directly and integrally related to the primary procedures performed at SBP.

(p) SBP Relationships with Laboratories and Other Providers

SBP shall monitor laboratory and other provider relationships with SBP to ensure that there are no Anti-Kickback or Stark violations. Specifically, the Chief Compliance Officer/Contact will examine such relationships to ensure that they reflect fair market value and are not tied to referrals or intended to ensure cross-referrals.

(q) Ownership Interests in SBP

- Existing and practicing physician owners in SBP should not refer patients, either directly or indirectly, to SBP.
- SBP will offer new investors equal terms of investment without regard to the volume or value of past or anticipated referrals or individual investors to SBP.
- Neither SBP nor other investors in SBP shall provide financial assistance for investment purposes to potential or existing investors.
- SBP must participate in the Medicare and Medicaid programs and neither SBP nor the investors shall discriminate against Medicare or Medicaid patients.

(r) Medical Information Privacy

As a covered entity, SBP will obtain the patient's acknowledgement prior to using or disclosing protected health information for any purpose other than to carry out treatment, payment, or health care operations. Patient information will be guarded and protected from inappropriate disclosure. Employees will be identified who need access to protected health information in order to carry out their duties. Employees who have authority to disclose information will limit the protected information provided to the amount reasonably necessary to achieve the purpose of the disclosure. SBP will adopt separate HIPAA Compliance Policies.

The Chief Compliance Officer/Contact shall act as the privacy official who is responsible for receiving complaints regarding privacy issues related to protected health care information.

Failure to act, when an employee has knowledge that someone is breaching the privacy protocols, shall also be considered a breach of that employee's responsibilities and shall subject the employee to disciplinary action by SBP, including possible termination of employment. Any employee who causes the breach to occur or is involved in the dissemination of protected health information shall be subject to disciplinary action by SBP, including possible termination of employment.

(s) Modification of this Compliance Plan

SBP shall modify this Compliance Plan as necessary to maintain compliance with the Anti-Kickback Statute, the Stark Law, and the False Claims Act, as well as all State anti-kickback, self-referral, and False Claims Act.

Any amendments to this Compliance Plan must be approved by the Compliance Committee by a majority vote.

If an amendment is made, all employees of SBP are required to review the amendment and sign an addendum acknowledging receipt and review of the new amendment.

(t) Annual Acknowledgement of this Compliance Plan

SBP employees as a condition of employment are required to review and acknowledge this plan on an annual basis even if no amendments are made.

Upon hire, new employees of SBP will be required to attend trainings and review and acknowledge this Compliance Plan.