

**NEW YORK CITY
HEALTH AND
HOSPITALS
CORPORATION**

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Corporate Compliance Plan

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A. INTRODUCTION

The New York City Health & Hospitals Corporation (“HHC” or the “Corporation”) is a public benefit corporation created under the laws of the State of New York pursuant to the New York City Health and Hospitals Corporation Act.¹ The purposes and the mission of HHC are to:²

- provide and deliver high quality, dignified and comprehensive care and treatment for the ill and infirm, both physical and mental, particularly to those who can least afford such services;
- extend equally to all we serve comprehensive health services of the highest quality, in an atmosphere of human care and respect;
- promote and protect as both innovator and advocate, the health, welfare and safety of the people of the State of New York and the City of New York;
- join with other health workers and with communities in a partnership which will enable each of our institutions to promote and protect health in its fullest sense – the total physical, mental and social well being of the people.

Since its creation, HHC has been committed to completing its mission while maintaining full compliance with all applicable laws, rules and regulations and ethical standards. This commitment to the highest ethical standards of behavior extends beyond our patients to everyone we deal with. The primary responsibility for insuring that HHC’s values are upheld lies with all employees, who are expected to be aware of and in full compliance with all applicable laws, rules and regulations, and avoid even the appearance of impropriety. It is critical that ethics and compliance be an integral part of every employee’s decision-making process. Inappropriate business ethics and non-compliant actions cannot and will not be tolerated and will be grounds for disciplinary action, up to and including termination of employment.

To help HHC fulfill its commitment to the highest ethical standards and foster a culture of compliance, the Compliance Program plays an important part in an overarching strategy to uphold HHC’s values. The Compliance Program establishes a process for education on relevant laws, rules and regulations; monitoring to ensure compliance; and documenting HHC’s efforts to obey the law.

This Corporate Compliance Plan (the “Plan” or the “Compliance Plan”) outlines and explains the structural and operational elements of the HHC Compliance Program and discusses some relevant laws, regulations, and policies and procedures. The Plan, which will be amended as warranted by changes in applicable laws and regulations, is distinct from the Compliance work plan (“WorkPlan”), which is prepared annually.

¹ See the New York City Health & Hospitals Corporation Act (L. 1969, C. 1016, eff. May 26, 1969)

² HHC Bylaws Article II Statement of Purposes, p.3, (as amended May 26, 2011); see also HHC Public Website [About HHC Our Mission](http://www.nyc.gov/html/hhc/html/about/mission.shtml) at <http://www.nyc.gov/html/hhc/html/about/mission.shtml>

B. GUIDING PRINCIPLES, FOUNDATION AND GOVERNANCE

I. Guiding Principles:

The Board of Directors (“Board”) at HHC, along with executive leadership, has long recognized the importance of having a robust infrastructure to address the ever-growing complexities of compliance issues found in the healthcare industry. Besides “address[ing] the public and private sectors’ mutual goals of reducing fraud and abuse”, the success of a compliance program can lead to enhanced healthcare operations, improved quality of care, and a reduction of healthcare costs.³ There are many benefits of an effective compliance program, including the following⁴:

- Demonstrating [HHC’s] commitment to honest and responsible corporate conduct
- Increasing the likelihood of preventing, identifying and correcting unlawful and unethical behavior at an early stage
- Encouraging employees to report potential problems to allow for appropriate internal inquiry and corrective action; and
- Through early detection and reporting, minimizing any financial loss to government and taxpayers, as well as any corresponding financial loss to the hospital.

The Board empowered the President to implement a compliance program aimed at creating a culture that promotes understanding of and adherence to applicable federal, state, and local laws and regulations and the Corporation’s ethical and business practices.

The goal of the HHC’s Compliance Program is to establish standards and procedures to: (i) prevent and detect criminal conduct, fraud, waste, and abuse⁵; (ii) to foster an organization environment that encourages ethical behavior and adherence to the law and ethical business practices; and (iii) to create a system of checks and balances designed “to prevent inaccurate billing and inappropriate practices in the Medicaid [and Medicare] program[s].”⁶

II. Foundation of Compliance Program:

HHC’s Compliance Program is modeled after and meets the requirements found in the Department of Social Services’s mandatory compliance program regulations.⁷ Additionally, the Program adopts the principles set forth in the 2010 Federal Sentencing Guidelines that cover effective compliance and ethics programs.⁸ Likewise, the Plan follows the guidance related to compliance provided by the Department of Health and Human Services Office of Inspector

³ 70 Fed. Reg. 4858, 4859 Department of Health and Human Services Office of the Inspector General OIG Supplemental Compliance Program Guidance for Hospitals (2005)

⁴ *Id.*

⁵ See Federal Sentencing Guidelines § 8B2.1(a)(1)

⁶ Office of the Medicaid Inspector General, Mandatory Compliance Programs, Frequently Asked Questions: *What is the Purpose and Intent of the Mandatory Compliance Law*, www.omig.ny.gov/data/content/view/79/65

⁷ 18 N.Y.C.R.R. part 521

⁸ 2010 Federal Sentencing Guidelines § 8B2.1

General's 1998 *Publication of the OIG Compliance Program Guidance for Hospitals* and its corresponding supplement, *OIG Supplemental Compliance Program Guidance for Hospitals*, issued in 2005, as well as other OIG guidance.⁹

HHC's Compliance Plan is the backbone of a comprehensive compliance program, which applies to several key compliance areas including, without limitation, "billings; payments; medical necessity and quality of care; governance; mandatory reporting; credentialing; and other risk areas that are" identified through HHC's compliance activities.¹⁰

HHC's Compliance Program complies with the eight elements set forth in the Department of Social Services regulations that cover mandatory compliance programs and fulfills the requirements of an effective compliance and ethics program found in the 2010 Federal Sentencing Guidelines. In summary, these elements and requirements are¹¹:

- 1) Establishment of written policies and procedures governing the compliance program;
- 2) Appointment of Corporate Compliance Officer who oversees the daily operation of the compliance program and reports to the President of the Corporation and periodically the Audit Committee of the Board of Directors;
- 3) Require mandatory training to all workforce members concerning compliance issues;
- 4) Provide open communication to the compliance officer to workforce members;
- 5) Development of disciplinary policies to encourage work force members to participate in the compliance program;
- 6) Development of system of ongoing assessment of areas of risk;
- 7) Development of a system to respond to compliance issues as they are raised; and
- 8) Implementation of policies that prohibit intimidation and retaliation for good faith participating in the compliance program.

In order to meet its legal requirements, adopted principles and internal standards of conduct, the President appointed a Corporate Compliance Officer ("CCO"). The CCO, who heads up HHC's Office of Compliance, is the chief officer in charge with directing compliance activities throughout HHC and is responsible for the day-to-day activities of the Compliance Program.¹² The CCO reports directly to the President, who, as the Chief Executive Officer at HHC, ensures the effectiveness of the Compliance Program.¹³ Additionally, the CCO periodically reports directly to a standing committee of the Board, the Audit Committee.¹⁴ Further, the CCO has direct access to the Audit Committee as warranted in his discretion.¹⁵ The Office of Compliance is described in detail, *infra*, at page 13, § [C][I][c].

⁹ See Department of Health & Human Services (HHS) Office of the Inspector General (OIG) Publication of the OIG Compliance Program Compliance for Hospitals (1998), see also 70 FR 4858 HHS OIG, OIG Supplemental Compliance Program Guidance for Hospitals (2005)

¹⁰ 18 N.Y.C.R.R. § 521.3[a][1-7]

¹¹ See *id.* at § 521.3[c][1-8]

¹² See, generally, 2010 Federal Sentencing Guidelines §8B2.1[b][2][C]; 18 N.Y.C.R.R. § 521.3[c][2]

¹³ See, generally, 2010 Federal Sentencing Guidelines §8B2.1[b][2][B]

¹⁴ See, generally, 2010 Federal Sentencing Guidelines §8B2.1[b][2][C]; 18 N.Y.C.R.R. § 521.3[c][2]

¹⁵ See, generally, 2010 Federal Sentencing Guidelines §8B2.1[b][2][C]

III. Governance: The Role of the Board in Compliance Activities:

The Board is the governing body of each facility operated by HHC. The Board is responsible for managing “[t]he business and affairs of the Corporation”¹⁶ These responsibilities must be fulfilled by the Board in a manner that is compliant with all applicable laws, rules, and regulations, including, but not limited to, regulations covering the conditions of participation in the Medicare program.¹⁷

With regard to compliance, the Board is responsible for:

- addressing noted compliance failures;
- ensuring that systems are in place to keep it informed of compliance issues as they arise; and
- “provid[ing] reasonable assurances of compliance.”¹⁸

In fact, the Office of the Medicaid Inspector General stated in its recently published 2011 Medicaid Workplan that, “it will be conducting investigations of significant compliance failures to determine the potential governance weaknesses, and to determine appropriate action, including possible censure and exclusion of board members”¹⁹

In addition to the establishment of the Office of Compliance, HHC, through its bylaws, has also established Standing and Special Committees of the Board that play key roles in HHC meeting its external and internal compliance requirements. These committees are the, Audit Committee, Quality Assurance Committee, and the Governance Committee.

a. Audit Committee

The Audit Committee is a standing committee of the Board. The Audit Committee is responsible for, among other things:²⁰ (i) approving, retaining or terminating selected independent auditors; (ii) being aware of all activities performed by independent auditors; (iii) reviewing annual financial statements; (iv) examining any findings prepared by independent auditors concerning “questionable or possibly illegal activities and take appropriate action;” (v) meet as necessary with independent auditors to address “problems that arise in connection with the audit” Moreover, the Audit Committee receives periodic reports from CCO on the effectiveness of the Compliance Program as well as compliance activities.²¹ As per HHC Operating Procedure (“OP”) 50-1 *Corporate Compliance Program*, the CCO “report[s] to the President with

¹⁶ HHC Bylaws Article IV § 1, p.5

¹⁷ *Id.*

¹⁸ NYS OMIG 2010-2011 Work Plan, *The Focus on Governance and its Relationship to the Compliance Function*, p.5

¹⁹ *Id.*

²⁰ HHC Bylaws, Article VI § 5 [A, C-F]

²¹ See, generally, 2010 Federal Sentencing Guidelines §8B2.1[b][2][C]; 18 N.Y.C.R.R. § 521.3[c][2]

supplemental (“dotted line”) direct access to the Audit Committee”²² Also, the Audit Committee has direct access to the CCO, as warranted.²³

b. Quality Assurance Committee

The Quality Assurance (QA) Committee is a standing committee of the Board.²⁴ The QA Committee oversees HHC’s obligations set forth under Public Health Law § 2805-j that require every hospital operated by HHC to establish and maintain a medical, dental and podiatric malpractice program.²⁵ This includes the establishment of a quality assurance committee that must include at least one member of the governing board of each hospital.²⁶ The QA committee is responsible for, among other things, reviewing the services delivered in the hospital with the focus on improving the quality of clinical services rendered to patients and to “prevent medical, dental and podiatric malpractice.”²⁷ Additionally, the QA Committee oversees the procedures involved in credentialing of clinicians and the process of granting clinical privileges; and reviews mandatory reported incidents.

c. Governance Committee

The Governance Committee is a special committee of the Board. This Committee, which was established by HHC as required by the Public Authorities Accountability Act of 2005, consists of the Chairperson of the Board and at least two other members of the Board of Directors. The duties of the Committee are to keep the Corporation’s Board of Directors informed of the current best governance requirements and current trends, update corporate governance principles and to advise appointing authorities on skills/requirements of the board members. Additionally, the Governance Committee addresses issues related to personnel policy and the appointment of corporate officers.

IV. Governance: Responsibility of the Board as Governing Body under Medicare, Medicaid, and Department of Health Regulations:²⁸

The Board, as governing body of each HHC facility, is responsible for the quality of care, hospital obligations, and legal compliance; hospital organization and operation; hospital compliance with federal, State and local laws; appointing a chief executive officer; determining medical staff eligibility; ensuring the implementation of patient care practices; providing an appropriate physical plant; services performed under hospital services contracts; developing an institutional plan and budget; and the provision of emergency services. Below is a general overview of these requirements.

²² HHC OP 50-1 § [1]

²³ *See id.*

²⁴ *See* HHC Bylaws, Article VI, § 2

²⁵ Public Health Law § 2805-j[1]

²⁶ *See id.* at § [1][a]

²⁷ *Id.*

²⁸ Generally, responsibilities of the Governing Body under Department of Health regulations and Medicare/Medicaid regulations may be found at 10 N.Y.C.R.R. § 405.2 and 42 C.F.R. § 482.12, respectively.

1. *Quality of Care, Hospital Obligations, and Compliance with applicable laws*

- the Board is responsible for the “quality of patient care services, for the conduct and obligations of each [HHC] hospital as an institution and for ensuring compliance with all Federal, State and local laws.”²⁹

2. *Organization and Operation*

- operating each HHC facility in a manner consistent with HHC’s mission;³⁰
- maintaining “generally accepted standards of professional practice and patient care services in [each HHC] hospital” by: (i) continually evaluating hospital services; (ii) causing the modification of policies and procedures as warranted; and (iii) identifying, examining, and resolving problems as they arise;³¹
- participating in orientation and educational sessions that address “the mission of [HHC], [the Board’s] roles and responsibilities, patients’ rights, and the organization, goals and operation of the hospitals quality assurance program[.]”³²
- adopting written bylaws that describe the Board’s legal responsibilities³³;
- holding meetings to evaluate the conduct of each HHC facility³⁴; and
- establishing a program designed to enhance quality of care and prevent malpractice.³⁵

3. *Compliance with Federal State and local laws*

- complying with Public Health Law, Mental Hygiene Law, and Education Law;³⁶ and
- taking the necessary action required to address any deficiencies in the hospitals’ compliance with applicable law including correction plans.³⁷

4. *Appointing a Chief Executive Officer*

- appointing a chief executive officer (“CEO”), qualified through education and experience, who is responsible to the governing body for the management of the hospital;³⁸
- monitoring the performance of the CEO³⁹;

²⁹ 10 N.Y.C.R.R. § 405.2[a]; *see also* 42 C.F.R. § 482.12

³⁰ *See* 10 N.Y.C.R.R. § 405.2[b][1]

³¹ *Id.* at § 405.2[b][2]

³² *Id.* at § 405.2[b][3]

³³ *Id.* at § 405.2[b][4]

³⁴ *Id.* at § 405.2[b][5]

³⁵ *Id.* at § 405.2[b][6]

³⁶ *Id.* at § 405.2[c][1]

³⁷ *Id.* at § 405.2[c][2]

³⁸ 10 N.Y.C.R.R. § 405.2[d][1]; *see also* 42 C.F.R. 482.12[d]

³⁹ 10 N.Y.C.R.R. § 405.[d][2]

5. *Determining Medical Staff Eligibility*

- “determine[ing], in accordance with State law, which categories of health care practitioners are eligible candidates for appointment to the medical staff;”⁴⁰
- appointing a medical director physician “responsible for directing the medical staff organization . . . ;”⁴¹;
- “require[ing] that members of the medical staff abide by the rules, regulations and bylaws of the hospital”⁴² and is accountable to the Board for the quality of care delivered to patients;⁴³
- requiring that each hospital medical staff has bylaws⁴⁴ and approving the same;⁴⁵

6. *Ensuring the implementation of Patient Care Practices*

- requiring that patient care practices “meet generally acceptable standards of professional practice;”⁴⁶
- requiring that every patient is under the care of a “health care practitioner who is a member of the medical staff;”⁴⁷
- requiring that a physician is “responsible for the care of each patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization;”⁴⁸
- requiring that hospital that conduct human subject research comply with Public Health Law statutes concerning research and adopt polices regarding the same;⁴⁹ and
- requiring that facilities “have available at all times personnel sufficient to meet patient care needs.”⁵⁰

7. *Providing an Appropriate Physical Plant*

- providing a physical plant equipped and staffed to maintain the needed facilities and services for patients in compliance with” regulatory construction standards “and for correcting deficiencies cited by regulatory agencies.”⁵¹

⁴⁰ *Id.* at § 405.2[e][1]; *see also* 42 C.F.R. § 482.12[a]

⁴¹ 10 N.Y.C.R.R. § 405.2[e][2]

⁴² *Id.* at § 405.2[e][9], [e][10]; *see also* 42 C.F.R. 482.12[a][5]

⁴³ 10 N.Y.C.R.R. § 405.2[e][10]

⁴⁴ *Id.* at § 405.2[e][7]

⁴⁵ *Id.* at § 405.2[e][8]

⁴⁶ *Id.* at § 405.2[f][1]; *see also* 42 C.F.R. § 482.12[c]

⁴⁷ 10 N.Y.C.R.R. § 405.2[f][2]; *see also* 42 C.F.R. § 482.12[c]

⁴⁸ 10 N.Y.C.R.R. § 405.2[f][5]

⁴⁹ *See id.* at § 405.2[f][6]

⁵⁰ *Id.* at § 405.2[f][7]

⁵¹ *Id.* at § 405.2[g]

8. *Services Furnished under Hospital Service Contracts*

- “Ensur[ing] that a contractor of services . . . furnishes services that permit the hospital to comply with all applicable codes, rules and regulations.”⁵²

9. *Developing an Institutional Plan and Budget*

- Developing an institutional plan and budget according to generally accepted accounting principles.⁵³

10. *Emergency Services*

- Ensuring that emergency services are provided in accordance with acceptable standards of practice and organized under the direction of a qualified member of the medical staff.⁵⁴

C. COMPLIANCE PROGRAM ELEMENTS (STRUCTURE AND OPERATIONS)

I. Written Policies and Procedures:

To clearly state its compliance expectations and to describe the Compliance Program and its approach to compliance, HHC has enacted several written policies and procedures organized logically for easy reference and conveniently located and easily accessible on the HHC intranet site. Some of those policies and procedures are described below. First among these is the HHC Principles of Professional Conduct.

a. HHC’s Principles of Professional Conduct

The Principles of Professional Conduct, which is given to every new employee at orientation, is a guide to help all HHC employees make sure they conduct official business in a manner that is both lawful and ethical. Employees, affiliates and vendors are advised that they must comply with the rules that apply to health care operations and to their particular duties.

All employees, affiliates and vendors are required to know and understand all the rules and policies that apply to their work, and to ask for guidance if they do not know what rules apply.

Employees are reminded that all who knowingly break HHC rules, state, federal, or local laws are subject to disciplinary action up to and including dismissal.

⁵² See 10 N.Y.C.R.R. § 405.2[h]; 42 C.F.R. § 482.12[e]

⁵³ See 42 C.F.R. § 482.12[d]

⁵⁴ See *id.* at 482.12[f][1]; see also 42 C.F.R. §§ 482.55, 482.55[a][1]

The policy on retaliation is clearly emphasized in the Principles of Professional Conduct:

- Any manager or supervisor who attempts to punish a subordinate for raising questions or trying to follow legal or ethical standards will be subject to disciplinary proceedings up to and including dismissal.

Importantly, specific guidance on compliance issues is given through examples of violations of professional conduct:

- Improper billing practices, including but not limited to:
 - Billing for items or services not rendered.
 - Upcoding – using a billing or DRG code that provides a higher payment rate than the correct code.
 - Submitting multiple claims for a single service or submitting a claim to more than one primary payer at the same time.
 - Submitting false cost reports.
 - Unbundling – submitting claims in a piecemeal or fragmented way to increase payment for tests or procedures that should be billed together.
 - Providing medically unnecessary services.
 - Retaining any overpayments.
- Submitting false statements or certifications in business dealings.
- Accepting gifts or services from a vendor. Unlawfully donating hospital funds, services and products, or other resources to any political cause, party or candidate.
- Giving or receiving anything of value for Medicare or Medicaid referrals.
- Improper disclosure of confidential patient information.
- Any violation of HHC policies concerning patient care or advance directives.

All personnel are advised to report concerns to supervisors, to Compliance or to make an anonymous report to the toll-free COMPLIANCE HELP LINE at: **1-866-HELP HHC**.

b. New York City’s Conflicts of Interest Law and the Code of Ethics of the New York City Health and Hospitals Corporation

- Conflicts of Interest Law⁵⁵

“Chapter 68 of the Charter of the City of New York defines a “code of ethics” which outlines the standards of conduct governing the relationship between private interests and the proper discharge of official duties of all corporate employees and directors.”⁵⁶ As it concerns HHC, the intent of the Conflicts of Interest Law is to prohibit employee conduct that could erode the “trust placed” in HHC’s employees, the “public[’s] confidence” in HHC, the “integrity of [HHC’s]

⁵⁵ Chapter 68 of the New York City Charter, § 2600 et seq.

⁵⁶ HHC Bylaws, Article XIX, Conflicts of Interest, p.33; *see also, generally*, Chapter 68 of the City Charter, § 2601[2][providing that HHC is subject to the Conflicts of Interest Law]

decision-making”, and the efficiency of HHC’s operations.⁵⁷ All HHC Board Members, officers, and employees are subject to “the Conflicts of Interest Law, whether they are paid or unpaid, whether they are full-time, part-time, or per diem, and regardless of their salary or rank.”⁵⁸ The Conflicts of Interest Board, which is the ethics Board for the City of New York, “is the independent, non-mayoral City agency charged with interpreting and enforcing the Conflicts of Interest Law”⁵⁹

- HHC Code of Ethics

“The Corporation has promulgated its own “Code of Ethics” which outlines the standards of conduct governing the relationship between private interests and the proper discharge of all members of the Corporation community advisory boards and its auxiliaries, and other personnel who are not covered by Chapter 68”⁶⁰ HHC’s Code of Ethics applies to “members of the Corporation’s Board of Directors, its officers and employees (including medical staff) Corporation Hospital Auxiliaries, Community Advisory Board members, and covered affiliate personnel.”⁶¹ Pursuant to the Code of Ethics, HHC has established a Committee on Conduct and Practice to implement the Code of Ethics and to provide advisory opinions as well as investigations and disciplinary actions.⁶²

- Questions concerning Chapter 68 or the Code of Ethics

Any questions regarding Chapter 68 can be directed to the Office of Legal Affairs (“OLA”) or the NYC Conflicts of Interest Board. Questions about the HHC Code of Ethics can be directed to the OLA. Formal requests for advisory opinions from the Committee on Conduct and Practice under the HHC Code of Ethics must be filed in writing with the Secretary of the Corporation.

c. HHC Operating Procedure 50-1: Corporate Compliance Program

This Operating Procedure (“OP”) details the structure of the Compliance Program, and provides information on the reporting obligations, responsibilities and expected procedures of the Corporate Compliance Officer (“CCO”) and Network Compliance Officers (“NCOs”). It defines the Executive Compliance Workgroup and Network-specific Compliance Committees. The responsibilities of the CCO and NCOs are also detailed in OP 50-1.

OP-50-1 identifies the Compliance Program as a resource for HHC, under the direction of the CCO, to prevent, detect and resolve HHC-wide and network-specific compliance issues and concerns.⁶³ To facilitate this, OP 50-1 makes clear that the CCO, consistent with federal, state

⁵⁷ Chapter 68 of the New York City Charter, § 2600.

⁵⁸ NYC Conflicts of Interest Board, About COIB, *Who is Covered by Chapter 68 of the City Charter, Conflicts of Interest Law?* accessed at http://www.nyc.gov/html/conflicts/html/about/about.shtml#chapter_68

⁵⁹ *Id.* at About COIB, *Conflicts of Interest Board*

⁶⁰ HHC Bylaws, Article XIX, Conflicts of Interest, p.33

⁶¹ HHC Code of Ethics, p.5

⁶² *Id.* at pages 2-3

⁶³ See HHC OP 50-1 §[1]

and local law, has reasonable access to all HHC areas and records.⁶⁴ The program is, in the absence of wrongdoing, intended to be non-punitive, consistent with HHC's non-retaliation policy, reiterated clearly in OP 50-1.⁶⁵

The CCO is responsible for providing appropriate training for the NCOs, and oversees the compliance training provided to all relevant HHC staff.⁶⁶ Additionally, the CCO oversees the development of the HHC Compliance Work Plan, reviews the Network Work Plans, and manages the network Compliance programs through the NCOs.⁶⁷ The CCO is authorized to conduct reviews and audits throughout the organization,⁶⁸ and has access to internal units, such as the Office of Internal Audits ("OIA") or the HHC Office of the Inspector General, and may request approval from the President to access outside resources, such as consultants, to accomplish this important function.⁶⁹

In support of the CCO's responsibilities, the OCC has internal written policies covering the creation and revision of OCC policies, the operation of the Help Line, the conduct of investigations, the tracking of compliance contacts, checking for excluded providers, and imposition of discipline for compliance violations.

d. HHC OP 30-1: Office of the Inspector General

HHC, unlike the vast majority of health care institutions, is a public institution, and is subject to a wide variety of additional regulations that are inapplicable to private/voluntary hospitals, e.g., regulatory and/or statutory schemes relating to construction, procurement, and conflicts of interest. Accordingly, as a public institution, HHC has an additional layer of oversight not found in the private sector, but commonly found in state and municipal government, i.e., an Office of the Inspector General ("IG").

As is the case with other Inspectors General, the IG has significant independence in conducting its investigations and audits. Pursuant to HHC OP 30-1, the IG reports only to the President and Chairman of the Board of Directors of HHC. Further, all officers and employees are subject and affirmatively obligated to cooperate with investigations conducted by the IG.

The IG's authority to conduct investigations is broad: the IG "shall have primary responsibility for conducting investigations on behalf of the Corporation, which it may delegate or refer in its sole discretion."⁷⁰ Its investigations encompass misconduct involving entities dealing directly or indirectly with HHC, "concerning fraudulent, corrupt or other criminal activity; conflicts of interest; unethical conduct; mismanagement; and serious violations of [HHC] rules or procedures."⁷¹ Further, no officer or employee is authorized to conduct investigations

⁶⁴ *Id.* at § [8]

⁶⁵ *See id.* at §§[1], [9], [10]

⁶⁶ *See id.* at §[4][A], [4][B]

⁶⁷ *See id.* at § [4][C]

⁶⁸ *See id.* at § [4][L]

⁶⁹ *See id.* at § [5][A]

⁷⁰ *See* HHC OP 30-1 § [4]

⁷¹ *Id.* at § [4][A]

“concerning corruption or other criminal activity or conflicts of interest without the prior approval of the Inspector General.”⁷²

In performing its mandate, the IG is given “immediate and unimpeded access to all areas of the Corporation, and to all documents and files in these areas.”⁷³ In addition, the IG serves as the HHC liaison with state, federal, and local law enforcement agencies, thereby enabling it, within the constraints of federal and state privacy laws, to provide for the prosecution of offenses for which it has adduced evidence in the course of its investigations.⁷⁴

In support of the functions of the IG, HHC OP 30-1 and a 2003 Directive by the HHC President place an affirmative obligation on all officers and employees to report information relating to known or suspected unethical, corrupt or criminal activity directly and confidentially to the IG.⁷⁵ The Directive prohibits any form of retaliation against anyone filing such a report with the IG, making such conduct a disciplinary offense that can result in termination of employment.

The activities of the IG are coordinated with the CCO to the extent that practical, legal, and ethical considerations allow. Both offices can and do refer matters to each other for review and consideration for further action. In addition, the IG makes frequent referrals and notifications to the Corporate HIPAA Security Officer and cooperates and conducts joint investigations with the OIA.

e. HHC Operating Procedures 240 and 250 series: Health Insurance Portability and Accountability Act

HHC’s efforts at ensuring compliance with the Health Insurance Portability and Accountability Act (“HIPAA”) are managed by the Corporate HIPAA Privacy and Security Office (“CPSO”),⁷⁶ working in conjunction with the Facility Privacy Officers (“FPOs”)⁷⁷ and the Network Security Officers (“NSOs”),⁷⁸ and in close cooperation with the HHC Corporate Security Officer, OLA, Human Resources and Labor Relations. The CPSO’s primary responsibilities include:

- ensuring that HHC is compliant with applicable federal and state laws and regulations pertaining to the privacy and security of protected health information (“PHI”);
- developing and implementing corporate HIPAA privacy and security policies and procedures;

⁷² *Id.* at § [5][C]

⁷³ *Id.* at § [5][B]

⁷⁴ *See id.* at § [4][C]

⁷⁵ *See id.* at § [5][D]

⁷⁶ In November 2007, the then distinct roles of Corporate Privacy Officer and Corporate HIPAA Security Officer were combined with the appointment of a Director of Corporate HIPAA Privacy and Security Compliance by the HHC Corporate Chief Information Officer (“Corporate CIO”). The Director of CPSO reports directly to the Corporate CIO.

⁷⁷ FPOs report directly to the Facility Chief Operating Officer or Chief Administrative Officer of their respective facilities. HHC OP No. 240-26 (*HIPAA Policy—Designation of Corporate and Facility Privacy Officers*).

⁷⁸ NSOs report directly to their respective Network Chief Information Officers. HHC Operating Procedure No. 250-07 (*HIPAA Security Policy—Assigned Security Responsibility*).

- working with FPOs and NSOs to assess the effectiveness of HHC’s privacy and security procedures;
- developing and/or implementing corporate-wide HIPAA privacy and security awareness training programs;
- tracking and coordinating the investigation of HIPAA privacy violations and breaches of PHI, whether in oral, paper or electronic (“EPHI”) format;
- mitigating the effects of privacy violations and security breaches, and providing required notice to affected parties and governmental organizations; and
- serving as HHC’s designated liaison to regulatory and accrediting bodies on matters related to health privacy and information security.⁷⁹

The FPOs primary responsibilities include:

- establishing standards for facility HIPAA compliance consistent with HHC policies and procedures and federal and state laws;
- assessing and monitoring facility privacy practices for compliance with HHC corporate HIPAA privacy policies and procedures, and applicable federal and state laws and regulations;
- receiving, recording, evaluating, investigating and remediating HIPAA privacy complaints received by the facility and/or assigned by the CPSO;
- assisting the CPSO with assessing potential breaches of PHI and administering breach notification when required by federal and/or state law and regulations; and
- developing awareness of health privacy issues among members of the facility workforce and, where necessary, developing facility training programs to supplement the corporate-mandated training program.⁸⁰

The NSOs primary responsibilities include:

- ensuring network compliance with applicable federal, state and local laws and regulations, as well as HHC policies and procedures, pertaining to the security of EPHI;
- confirming that adequate administrative, physical, and technical safeguards and controls are in place to protect EPHI;
- ensuring that a network inventory of systems that contain EPHI is kept current and confirming that corporate-wide HIPAA security risk assessments are completed periodically;
- monitoring, evaluating and mitigating threats to the confidentiality, integrity and availability of EPHI;
- working in conjunction with the FPO and the CPSO to ensure that security policies and procedures support compliance with the HHC HIPAA privacy policies and procedures;
- assisting in the investigation of security incidents and promptly notifying the CPSO of any breaches of information that involve EPHI; and
- assisting the CPSO with assessing potential breaches of PHI and administering breach notification when required by federal and/or state law and regulations.⁸¹

⁷⁹ For a full and complete listing of CPSO responsibilities, see HHC OP Nos. 240-26 and 250-07.

⁸⁰ See HHC OP No. 240-26 for a full and complete list of FPO responsibilities.

⁸¹ See HHC OP No. 250-07 for a full and complete list of NSO responsibilities.

HIPAA Privacy and Security Operating Procedures are developed, implemented, and amended by the CPSO to meet the requirements of state law and federal HIPAA Privacy and Security Rules.⁸² There are currently 28 HIPAA Privacy Operating Procedures, comprising Series 240 of HHC's Operating Procedures, and 21 HIPAA Security Operating Procedures, comprising Series 250. These policies and procedures are periodically reviewed and updated as required by changes in state law, federal HIPAA regulations or HHC operating conditions. Some key policies and procedures are those concerning privacy procedures, security procedures, HIPAA violations, breach notification, and business associates.

1. Privacy Procedures

- Notice of Privacy Practices ("NPP")

HHC has adopted one enterprise-wide notice, which has been translated into thirteen languages and is available to be read in Braille. HHC provides copies of the NPP to all patients and patients' personal representatives during their initial encounter, and upon request. All HHC facilities are directed to mount and prominently post a copy of NPP next to the Patient Bill of Rights in key registration and admitting areas. Registration and/or Admitting staff is required to make a good faith effort to secure the patient's or patient representative's written acknowledgment that the patient received the NPP.⁸³

- Patient Access to PHI

HHC has implemented procedures that permit a patient or a patient's personal representative to request access to inspect and/or obtain a copy of his or her designated record set held by each HHC facility or its business associates, for as long as the PHI is maintained in the designated record set.⁸⁴

- Disclosures of PHI

Each HHC facility is required to make reasonable efforts to safeguard PHI maintained by that facility. The HHC facility may use and disclose PHI without authorization for treatment, payment and healthcare operations. No HHC facility shall otherwise use such individual's PHI without that individual's explicit authorization. HHC facilities shall disclose PHI only upon authorization by the patient or patient's personal representative, unless as otherwise specifically permitted by state or federal law.⁸⁵

⁸² All draft HIPAA Privacy or Security Operating Procedures, or amendments thereto, are reviewed by OLA prior to submission to the HHC President's Office.

⁸³ See HHC OP No. 240-01 (*HIPAA Policy on Deployment of the Corporate Privacy Notice*).

⁸⁴ See HHC OP Nos: 240-04 (*HIPAA Policy - Patient Access to Protected Health Information*) and 240-10: (*HIPAA Privacy Policy - Personal Representative (Health Care Agents)*).

⁸⁵ See HHC OP No: 240-14 (*HIPAA Policy - Patient Authorization*).

- HIPAA Privacy Self Assessment

Self-Directed HIPAA Privacy Assessments (“Assessment”) are conducted at least quarterly at each HHC network, agency and corporate office. The purpose of the Assessment is to evaluate compliance with the standards set forth in HHC’s HIPAA Privacy Operating Procedures, to provide a gauge or benchmark for performance and to implement corrective action plans as necessary. The FPO is responsible for conducting and/or overseeing the Assessment for his or her designated network, agency or corporate office.

2. Security Procedures

- Security Risk Assessments

HHC has developed and implemented policies and procedures to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of EPHI held by HHC. HHC and its networks, facilities and agencies are responsible for conducting security risk assessments, not less than annually, to determine compliance with HHC’s operating procedures.⁸⁶

- System Access Audit

In accordance with federal laws and regulations, HHC Operating Procedures Nos. 250-06 (*HIPAA Security Policy—Information Access Management*), 250-08 (*HIPAA Security Policy—Workforce Security*), 250-16 (*HIPAA Security Policy—Access Control*) and 250-18 (*HIPAA Security Policy—Person and Entity Authentication*), and Corporate Office of Information Services (“IS”) policies, standards and procedures and internationally accepted information security best practices, HHC and its networks, facilities and agencies conduct periodic System Access Audits. Audits are conducted at intervals not less than every 90 days to assess the appropriateness of user account management and identity management internal controls and internal business practices.

- Workstation Use and Security

HHC has developed and implemented policies and procedures that specify appropriate functions to be performed on computer workstations that access EPHI, the manner in which these functions are to be performed, and the physical characteristics of such workstations.⁸⁷

- Device and Media Controls

HHC has developed and implemented policies and procedures to address the final disposition of EPHI, and the hardware and software on which it is stored; the removal of EPHI from electronic media before the media is made available; maintaining a record of the movements of hardware

⁸⁶ See HHC OP No. 250-02 (*HIPAA Policy and Procedure - Security Risk Analysis*).

⁸⁷ See HHC OP No. 250-05 (*HIPAA Security Policy - Workstation Use and Security*).

and electronic media and the persons responsible therefore; and creating a retrievable, exact copy of EPHI, when needed, before movement of equipment.⁸⁸

- Transmission Security

HHC has implemented technical security measures to guard against unauthorized access to EPHI that is being transmitted over an electronic communications network.⁸⁹

- Remote Use and Access

HHC and its networks, facilities and agencies have implemented procedures to protect EPHI transmitted offsite, or remotely accessed or stored utilizing portable devices, removable media, or external systems or hardware.⁹⁰

3. *HIPAA Violations*

When there is an issue, pursuant to the HIPAA Privacy Rule and HHC OPs, HHC provides a process for privacy complaints to be filed, tracked, investigated and resolved. Complaints may be made by filing a written complaint or via the toll-free HHC Compliance Helpline (1-866-HELP-HHC) or by email directed to the Corporate Privacy Officer (CPO@nychhc.org). Complaints received by an HHC facility are reported to the CPSO within 48 hours.

The CPSO may either resolve an issue itself or assign the complaint to the appropriate FPO for review and resolution. Within ten days of assignment, the FPO will report back on preliminary findings and, where possible, notify the complainant in writing that the complaint was received and is being reviewed. All complaints are tracked on the HIPAA Complaint Tracking System maintained by the IS. Access to the system is restricted to each of the FPOs for his or her respective facility/network, and the CPSO for corporate-wide monitoring.

The CPSO may supervise or conduct investigations concerning alleged violations of HIPAA or other relevant privacy laws at the direction of OLA. When workforce members are determined to have violated HHC HIPAA policies and procedures, the CPSO works with Human Resources Departments and the Office of Labor Relations to ensure that an appropriate sanction is imposed.

Security violations involving EPHI are reported, tracked, and investigated in accordance with IS policies and procedures. However, pursuant to HHC OP No. 250-10, when a IS breach occurs that involves EPHI, the NSO is required to notify the CPSO.

4. *Breach Notification*

Pursuant to Part 164, Subpart D, of the HIPAA Privacy Rule, HHC provides notice to affected parties when there is a HIPAA privacy violation involving the unauthorized use or disclosure of unsecured PHI that poses a significant risk of financial, reputational or other harm to the

⁸⁸ See HHC OP No. 250-15 (*HIPAA Security Policy – Device and Media Controls*).

⁸⁹ See HHC OP No. 250- 19 (*HIPAA Security Policy - Transmission Security*).

⁹⁰ See HHC OP No. 250- 20: (*HIPAA Security Policy - Remote Use and Access to Electronic Protected Health Information*).

individuals.⁹¹ The CPSO coordinates the tracking and investigation of potential HIPAA breaches at the direction of OLA. Once OLA determines that, as a matter of law, a HIPAA breach has occurred, the CPSO administers the process of notification. The notification process includes drafting a written notice subject to OLA approval and coordinating the printing and mailing of the notice in a reasonable period not greater than sixty days from discovery of the breach. HHC provides required follow-up contact for an affected party via a toll-free telephone number, email address or web page posting. Information requests are handled by the CPSO, FPOs/NSOs or third-party vendors (business associates).

The CPSO notifies the Secretary of the Department of Health and Human Services regarding HIPAA breaches—either at the same time that affected parties are notified if the breach involves more than 500 individuals, or within sixty days of the conclusion of the calendar year for smaller breaches—and assists HHC Communications in preparing required media notices and web-site announcements. Records of the breach notification process are maintained by the CPSO.

5. *Business Associates (“BAs”)*

HHC meets the HIPAA requirement regarding the disclosure of patient PHI to BAs, and the creation or receipt of PHI by BAs, by having third-party vendors and service providers execute a business associate agreement (“BAA”) prepared by OLA. The BAA is a vehicle for HHC to obtain adequate assurances that the BAs will appropriately safeguard PHI and immediately inform HHC of any privacy violations and reaches of PHI in connection with their services on behalf of HHC. OLA reviews and updates the BAA as required by changes in law and corporate procedures.⁹²

f. **HHC Operating Procedure 160-1 and 1991 Board Policy: HHC Research Policy and Guidelines**

- HHC Review, Approval and Cost Recovery from Affiliation-Sponsored Research Activities Performed in Corporation Facilities

This Operating Procedure (“OP”) establishes a standard procedure for obtaining HHC review and approval of Affiliation-Sponsored research activities which are to be performed in HHC facilities, as well as assuring compliance with HHC’s Research Policy as adopted by the Board of Directors on September 9, 1976. This document also serves to outline procedures around alerting Central Office to proposed research activity in the facility, as well as reimbursing HHC for all costs associated with the performance of research activities by the Affiliates in HHC facilities. The document outlines the responsibilities of facility Executive Directors, Affiliates, The Office of Affiliations (Grants) and the Office of Finance.

- HHC Clinical Investigation & Research Policy and Guidelines.

⁹¹ The Director of CPSO, as the HHC Privacy Officer, also provides notice to affected parties pursuant to New York General Business Law §899-aa when OLA determines that private information has been compromised.

⁹² The BAA also includes terms and conditions that reflect federal and state law concerning confidentiality of patient information besides HIPAA.

This Policy and Guidelines document (“1991 Board Policy”) sets forth the HHC policy statement for human subject research, as well as guidelines for conducting such research, including applicability, basic research principles, the HHC research review and approval process, additional safeguards based on the Office of Human Research Protection’s (“OHRP’s”) list of groups deemed vulnerable populations, and any other corporate, facility or audit procedures related to research.

g. HHC Operating Procedure 120 -19: Record Retention and Disposal

HHC OP 120-19 establishes a standard practice for the retention and disposal of corporate records throughout all HHC facilities.⁹³ Under this procedure, a Records Retention Council (RRC) was formed and charged with the “responsib[ility] for assuring that the Corporation’s record retention policy is implemented in an efficient and uniform manner throughout the Corporation.”⁹⁴ Additionally, 120-19 charges the Corporate Records Management Officer with “working with the State Archives and Records Administration (SARA) and updating the corporate record retention and disposal procedure/schedule”⁹⁵ All HHC record retention activities are subject to Arts and Cultural Affairs Law Article 57-A and its implementing regulations found at 8 NYCRR part 185, as well as all other applicable laws, rules, regulations that cover records and information governance.

II. Corporate Compliance Officer:

The day-to-day operation of the Program is the responsibility of the CCO, who is “to direct compliance activities across the Corporation”⁹⁶ The CCO is responsible for, among other things, training and educating compliance staff and HHC employees and affiliates, ensuring the development of corporate and network compliance work plans, maintaining confidential processes to receive complaints, and responding to compliance issues.⁹⁷

To effectuate that mandate, “all dedicated Compliance staff, whether they are located in the Corporate Compliance Office or at HHC facilities, shall be under the direction and control of the CCO”⁹⁸ Additionally, the CCO is “given reasonable access to any area within the Corporation and to all documents and files in these areas, as well as the authority to examine and copy any document or file necessary to fulfill his/her responsibilities to conduct a review into compliance-related matters.”⁹⁹ The CCO also can “delegate to appropriate employees or departments (such as Internal Audits or the Inspector General) the responsibility to conduct reviews of issues of concern” or “retain outside consultants such as investigators, attorneys, auditors, training specialists or others with specific expertise to assist in selected reviews or the development of the compliance program”¹⁰⁰

⁹³ OP 120-19 § [1-2]

⁹⁴ *Id.* at § [3][h]

⁹⁵ *Id.* at § [3][d]

⁹⁶ HHC OP 50-1, § [3][A]

⁹⁷ *See id.* at §[4]

⁹⁸ *Id.* at § [3][C]

⁹⁹ *Id.* at § [8]

¹⁰⁰ *Id.* at §[5][A]

a. Reporting

The CCO reports to “the President with supplemental (“dotted line”) direct access to the Audit Committee of the Corporation’s Board of Directors. Similarly, the Audit Committee will have direct access to the CCO.”¹⁰¹ Additionally, the CCO is expected to “report on significant Compliance activity in quarterly meetings with the Chairperson of the Audit Committee, the Chairperson of the Board of Directors, and the HHC President.”¹⁰²

On selected matters, the CCO can exercise discretion to “report directly to the Chairperson of the Audit Committee”¹⁰³

b. The Executive Compliance Workgroup

To provide “advice and guidance to the CCO,” the Executive Compliance Workgroup (“ECW”) has been created.¹⁰⁴ It is “chaired by the Corporate Compliance Officer and Executive/Senior Vice President for Operations (or Corporate Chief Operating Officer), and includes the General Counsel (or designee), the Corporate Chief Medical Officer, the Corporation’s Chief Financial Officer, the Associate Vice President for Revenue Management, the Chief Information Officer, and a Network Senior Vice President and a Network Chief Financial Officer, each of whom will be selected by the President and will serve on the ECW for a term of one year.”¹⁰⁵

The Corporate Chief Financial Officer and the Senior Assistant Vice President for Revenue Management serve as subject-matter experts on billing and reimbursement and play active roles in implementing the corporate compliance work groups. They take leadership on key projects involving researching rules and regulations, providing training, and engaging in process improvement activities. These process improvements often take a corporate view on billing in a particular service line. Standard work is developed and training is provided to clinicians, coders, and billing staff. New policies are implemented to strengthen existing controls as needed.

The General Counsel (or designee), as a member of the ECW, provides advice and guidance to the CCO and the ECW. As counsel to HHC, the OLA is responsible for all legal advice provided to the Corporation and is committed to helping HHC carry out its core mission in a legally compliant manner. To that end, OLA, along with retained outside counsel, is available for consultation and guidance in connection with legal issues concerning relevant compliance matters.

c. The Network Compliance Officers

Network Compliance Officers, who can be hired or removed only upon approval of the President, “are defined as Compliance Officers who serve at Networks, facilities . . . and HHC

¹⁰¹ *Id.* at § [3][A]

¹⁰² *Id.* at §[3][B]

¹⁰³ *Id.*

¹⁰⁴ *Id.* at § [3][D]

¹⁰⁵ *Id.*

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Health and Home Care.”¹⁰⁶ NCOs report to the COO and “function solely in the role of Compliance Officer, unless other responsibilities are expressly approved by the President.”¹⁰⁷

NCOs, under the direction of the CCO, are responsible for furthering the Compliance Program.¹⁰⁸ They will, among other things, contribute to the creation of corporate and network risk assessments and work plans, review and respond to compliance issues, conduct necessary training and education, and ensure the effective functioning of the Network Compliance Committees.¹⁰⁹

d. Network Compliance Committees

Network Compliance Committees (“NCCs”) are chaired by the local NCO.¹¹⁰ “With the approval of the President, NCCs may be co-chaired by the Network Senior Vice President or his/her senior-level designee. NCCs will include network facility members appointed by the Network Senior Vice President from the Departments of Finance, Patient Accounts, Quality Assurance, Health Information Management, Audit, Medicine, Utilization Review, Environmental, Information Technology, and other departments as needed.”¹¹¹

The NCC will, among other things, participate in the development and implementation of risk assessments and work plans, help review and investigate possible compliance violations and internal controls, and help implement corrective action plans as necessary.

e. Office of Patient Safety

The Office of Patient Safety (OPS) is responsible for promoting and nurturing a culture of safety in HHC facilities. The goal is to reduce and prevent inadvertent harm to patients as a result of care provided at HHC. OPS strives to improve processes, engage staff in teamwork and communication, and develop programs that will enhance patient safety across all levels of care at HHC. This work is accomplished through the guidance of the Corporate Patient Safety Committee, Chaired by the Senior Vice President, Patient Safety and operationalized at the facility level by the Patient Safety Officers and Patient Safety Associates with the support of their executive leadership.

OPS provides a range of activities and services including: Convening Senior Leadership Forums on Patient Safety; large scale patient safety events for facility staff (Patient Safety Expo, annual patient safety champions awards and recognition); patient safety education and training for facility staff on strategic priorities (e.g., TeamSTEPPS and The Just Culture); development of patient safety curricula and educational materials; development and dissemination of “Patient Safety Alerts”; annual Patient Safety Culture Survey; development and maintenance of the Corporate Patient Safety Gateway intranet site; convening the facility Patient Safety Officers,

¹⁰⁶ *Id.* at § [3][E]

¹⁰⁷ *Id.*

¹⁰⁸ *See id.* at § [6]

¹⁰⁹ *See id.*

¹¹⁰ *See id.* at §[3][G]

¹¹¹ *Id.*

Patient Safety Curriculum Committee, and Medication Safety Council. The Office was instrumental in organizing the Citywide Council of Patient Safety Officers comprised of representatives of voluntary hospitals across NYC and served as Chair of the Committee.

The Office of Accreditation and Regulatory Services (A&RS) is responsible for assuring ongoing Governing Body oversight and HHC facility compliance with external accreditation and regulatory agency requirements (e.g., TJC, CMS, and NYSDOH). These activities are monitored through a Continuous Survey Readiness (CSR) Program implemented by the Senior Director and staff, under the direction of the Senior Vice President. The CSR program includes: on site mock surveys and technical assistance at the HHC facilities; participating on-site during facility surveys; assisting facilities to prepare responses to statements of deficiency; educational programs to assure a workforce that is knowledgeable and competent on external agency requirements and how to operationalize them; convening the regulatory affairs administrators, JC Coordinators, ORYX Coordinators; development of policy procedures and guidelines (e.g., HHC Consent Policy and Forms, Guidelines for Defining, Reporting and Eliminating Intimidating, Disruptive and Unacceptable Behavior Among all Staff); overseeing the contract and monitoring compliance to TJC and CMS Core Measures.

HHC's facilities are licensed to operate by the NYSDOH. All of the Corporation's acute care hospitals and long-term care facilities are subject to Federal surveys with respect to Medicare *Conditions of Participation*, such as the periodic "Title 18 Survey" for acute care hospitals and the annual Omnibus Budget Reconciliation Act Survey for long-term care facilities ("OBRA Survey"). State surveys are conducted with respect to regulatory matters (such as the "Article 28 Survey") and regular medical record reviews by the State's Peer Review Organization and other regulatory agencies. In addition, 15 of the Corporation's acute and long-term care Facilities voluntarily participate in the accreditation process of The Joint Commission ("TJC"), which conducts surveys of these facilities approximately every three years on an unannounced basis. Currently, all of the Facilities participating in The Joint Commission's accreditation process are fully accredited.

f. Office of Internal Audits

The primary role of the OIA within HHC is to perform operational and financial audits throughout the organization, act as an intermediary for audits conducted by regulatory agencies, assist the Corporation's external accounting firm with its annual examination and, when needed, perform evaluations requested by management.

Although the OIA has a distinct function and operates separately from the OCC, their responsibilities and duties continually intertwine. Both monitor business units to promote compliance with regulations, policies, and guidelines. In addition, both conduct periodic monitoring of business units and report exceptions to management. Both also need to remain up-to-date on business initiatives and compliance changes and require strong communication networks within their respective groups and with the organization's business units.

The types of compliance audits performed by OIA usually involve ensuring whether a process or transaction is or is not following applicable rules. Examples include audits of employee pensions

and benefits and government grants. In addition, one of the primary objectives of the audits of the affiliations is to ensure compliance with the contractual agreements.

There are also key differences between OIA and OCC. Internal auditing is an independent function and its role in the organization is more broadly defined – it is not limited to compliance reviews. The OIA provides periodic assurance to the Board and executive management on the organization’s ability to achieve its objectives by evaluating its control structure. The OCC, on the other hand, is part of the control structure of the organization.

During the course of their reviews both OIA and OCC may request the services of each other’s expertise. For instance, OCC may suggest to OIA that an area be audited if it determines during its review that inadequate controls exist.

The lines of communication between OCC and OIA must be open for each group to be effective. The Chief Internal Auditor meets bi-monthly with the CCO to discuss issues of similar importance, and other communications are exchanged more frequently as warranted. The annual plans of each department are shared to ensure full coverage and that overlapping does not occur. In addition, OCC is on the distribution list for all relevant internal audit reports.

g. Central Office Finance

There are several divisions within Central Office Finance (“COF”) that play an important role in insuring HHC’s compliance with applicable laws, rules and regulations and that work with the CCO: Revenue Management, Reimbursement, Managed Care, and the Corporate Comptroller’s Office. These divisions set policy, design systems and standard work, and provide training and guidance to the facility Finance operations staff on billing, documentation and coding, proper maintenance of books and records, cost report preparation, and internal controls related to the preparation of HHC’s annual Financial Statement. They work with the OLA and outside counsel in interpreting laws, regulations and rules, as well as adapting to external change.

These COF divisions have routine monthly meetings with the hospital patient account directors, reimbursement directors, and controllers. These forums provide important channels for hospital staff to identify potential compliance issues. Once identified, these issues are brought to the attention of the CCO. These forums are also used as a vehicle for assisting the CCO in its annual risk assessment process. In addition, COF infuses compliance into the development of policies, standard work, and systems. Compliance is an important consideration in many COF processes, including:

- Standard work, which outlines step-by-step procedures for each function from registration, insurance verification through billing and accounts receivable management, is currently being finalized through the Revenue Process Transformation Breakthrough efforts so that every hospital and diagnostic and treatment center performs these functions completely and in a uniform way.
- Wherever possible, it is the goal of the Corporation to enforce compliance through systems edits in the billing systems, such as building tables that allow only valid

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diagnosis and procedure codes to be entered on a claim. Billing policies are also incorporated into the system in the form of cautionary alerts that help the provider and, to some extent, the coders select the codes or data that ensure that claims only include services that are medically necessary and billed in compliance with the law. Whenever technically possible, COF has built into the patient accounting and patient registration system the same edits used by Medicaid and Medicare in their claims processing applications. These edits, which are only guides and tools, allow HHC to optimize revenue and help to minimize non-compliant claims submission. Still, payer edits change quickly and systems cannot completely take the place of human judgment and practice.

- Medicaid applications statistics are monitored and reported quarterly to the Finance Committee of the Board. HHC staff work very closely with New York City Human Resources Administration (“HRA”) staff with respect to Medicaid application and documentation submission rules. In support of that collaboration, a Medicaid application submission and tracking system that contains edits that are similar to those used by HRA in the processing of the applications has been implemented.
- Revenue Management staff is in touch with the appropriate staff at the New York State Department of Health (“DOH”) to review protocols and regulations pertaining to Medicaid. There are similar direct lines of communication with other payers and regulators. This has led to close working relationships with various state and federal regulators that help keep HHC up to date on new billing policies and ensures that HHC’s concerns and needs are understood by the third parties. COF staff often consults with these regulatory experts and provide important feedback to the CCO. Also, COF will report issues to these regulators and voluntarily return overpayments.
- HHC Options. With the passage of the State Financial Assistance law, HHC’s existing fee-scaling policies were used as the model for the implementation of bill reduction procedures and the calculation of charity care allowances. HHC was able to automate the fee-scaling process for both inpatient and outpatient accounts and to generate fee-scaling statistics as required by the new Cost Report Exhibits for Bad Debt Charity Care pool calculations.
- New reimbursement - PCs, APR, APGs. By overseeing the loading of reimbursement rates in the financial system, Revenue Management is able to ensure that claims are accurate and correctly formatted. Relevant billing edits and rules have been implemented within the patient accounting system so that claims are stopped prior to submission should they contain any fatal errors.
- The Charge Description Master (“CDM”) is reviewed by Revenue Management and Reimbursement services twice a year and tools such as Craneware are used to ensure that information contained on claims is as accurate as possible. Additionally, HHC’s practice is to conduct a review of the CDM anytime programmatic changes occur. Examples of such changes are changes in regulations, implementation of APG/APC’s or the introduction of new or amended CPT’s.

COF staff manages the annual external audit of HHC's books and records and internal controls. HHC's outside audit firm will make observations of areas where management controls can be strengthened particularly in the Corporation's management of its accounts receivable. COF will monitor the implementation of corrective action plans designed to improve these processes. Moreover, COF coordinates the completion and filing of the New York City Comptroller's Directive #1, a very comprehensive internal control questionnaire covering all areas of finance operations as well as IT controls. The Corporate Comptroller's Office reviews the filings of the individual facilities prior to submission.

The HHC Compliance Program is dependent on the support of all HHC employees and key departments. That is why OP 50-1 makes clear that "every officer and employee will be advised that he/she has an affirmative obligation to cooperate with a review conducted by the CCO or his/her delegated representatives."

Ultimately, compliance needs to be part of HHC's every day work. For the Compliance Program to be effective, all supervisors and members of management must be aware that they have a responsibility to understand the principles outlined in our Principles of Professional Conduct. Furthermore, they have an obligation to understand the specific compliance risks including the potential for fraud, waste, abuse or misconduct that pertain to their areas of responsibility. In addition, management must:

- Develop, implement and maintain standards, policies and procedures relevant to their areas of responsibility;
- Provide training to all of their employees on these standards, policies and procedures, and, along with the Compliance staff, provide training on relevant laws and regulations;
- Develop auditing and/or monitoring procedures to be used to periodically determine that standards, policies and procedures are being adhered to;
- Enforce the elements of the Principles of Professional Conduct as well as those of applicable policies and procedures, laws and regulations;
- Facilitate the investigation of any suspected instances of violations of the Principles of Professional Conduct as well as any suspected instances of fraud, waste or abuse or misconduct; and
- Report any suspected violations of laws or regulations to the OCC or the Compliance Helpline in order to facilitate corrective actions as may be necessary.

h. Office of Research Administration

The Office of Research Administration ("RA") was created to implement, administer and oversee a wide variety of activities pertaining to the human subject research ("research") operations at HHC. The office's primary responsibility is to ensure that the rights and welfare of HHC patients who volunteer as research participants are protected as per State and Federal laws, rules, codes, and regulations¹¹² as well as internal procedures.¹¹³

¹¹² See, generally, 45 CFR part 46; see also, generally, Public Health Law Article 24-A (Public Health Law §§ 2440 et seq.); 21 CFR parts 50, 56, 312 & 812; 34 CFR parts 50, 56, 98 & 99; 10 NYCRR §§ 405.2[f][6] & 405.7[b][18], [c][12]

- Compliance with terms of Federalwide Assurance (“FWA”)

RA assures that all research conducted at HHC meets all terms outlined in a written assurance between HHC and The Department of Health and Human Services Office of Human Research Protections (“OHRP”), which include, without limitation, compliance with 45 CFR part 46.¹¹⁴ This written assurance, referred to as a Federal Wide Assurance (“FWA”), requires, among other things, that research performed at HHC-operated facilities be guided by “[a] statement of principles governing [each facility] in the discharge of its responsibilities for protecting the rights and welfare of human subjects of research conducted at or sponsored by [HHC]”¹¹⁵ To satisfy this requirement, HHC has adopted the Belmont Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (the “Belmont Report”).¹¹⁶ The terms of the FWA also include mandatory compliance with all applicable, Federal, State, and local laws, rules and regulations concerning human subject research.¹¹⁷

- Role of the FWA Signatory Official and Human Protections Administrator

As the signatory official on HHC’s FWA, HHC’s Chief Medical Officer (“CMO”) is the “individual authorized to act for [HHC] and to assume on behalf of [HHC] the obligations imposed by [45 CFR part 46]”¹¹⁸ Additionally, as the FWA signatory official, HHC’s CMO is responsible for assuring compliance with all the terms outlined in the FWA.¹¹⁹ Pursuant to the terms of its FWA, HHC was required to designate a Human Protections Administrator (“HPA”). The Director of the RA serves as HHC’s HPA and is responsible for “hav[ing] comprehensive knowledge of all aspects of [HHC’s] system of protections for human subjects, as well as . . . familiar[ity] with [HHC’s] commitments under the FWA, and play[ing] a key role in ensuring that [HHC] fulfills its responsibilities under the FWA.”¹²⁰ In summary, the Director of RA exercises operational responsibility for managing the processes that protect human subjects of research conducted under the FWA.

- Role of institutional review boards

All human subject research conducted by or approved by HHC must be approved by an institutional review board (“IRB”) registered with OHRP.¹²¹ An approving IRB must consist of no fewer than “five members, with varying backgrounds to promote complete and adequate

¹¹³ HHC OP No. 160-1 (*HHC Review, Approval and Cost Recovery from Affiliation-Sponsored Research Activities Performed in Corporation Facilities*) and 1991 Board-Approved Policy entitled “*HHC Clinical Investigation & Research Policy and Guidelines*”

¹¹⁴ See 45 CFR § 46.103[a].

¹¹⁵ *Id.* at § 46.103[b][1]; see also, generally, Public Health Law § 2444[2]

¹¹⁶ See the Belmont Report at <http://www.hhs.gov/ohrp/policy/belmont.html>

¹¹⁷ See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) OFFICE FOR HUMAN RESEARCH PROTECTIONS (OHRP) FederalWide Assurance (FWA) for the Protection of Human (FWA) for the Protection of Human Subjects, Terms of the FederalWide Assurance for the Protection Of Human Subjects (FWA), § 3[c], accessed at <http://www.hhs.gov/ohrp/assurances/assurances/filasurt.html>

¹¹⁸ 45 CFR § 46.103[c].

¹¹⁹ Federalwide Assurance (FWA) for the Protection of Human Subjects filing form (OMB Form No. 0990-0278) § 8, accessed at <http://www.hhs.gov/ohrp/assurances/assurances/fwaform.docx>; see also HHS OHRP Federalwide Assurance Instructions, Step-by-Step Instructions for filing a Federalwide Assurance, Item # “8”, accessed at <http://www.hhs.gov/ohrp/assurances/forms/fwainstructions.html>

¹²⁰ HHS OHRP Federalwide Assurance Instructions, Step-by-Step Instructions for filing a Federalwide Assurance, Item # “7”, accessed at <http://www.hhs.gov/ohrp/assurances/forms/fwainstructions.html>

¹²¹ *Id.* at Item # (“6”); see also Public Health Law § 2444[1]; 45 CFR § 46.109[a]

review of research activities commonly conducted by the institution.¹²² The IRB shall be sufficiently qualified through the experience and expertise of its members, and diversity of the members”¹²³ The IRB is responsible for, in pertinent part, the following: (i) following written procedures that govern “its initial and continuing review of research . . . ; (ii) for determining which projects require review more than annually . . . ; and (iii) for ensuring prompt reporting to the IRB of proposed changes in a research activity”¹²⁴ The IRB is also responsible for, among a host of other obligations, “ensuring prompt reporting to the IRB, appropriate [HHC] officials . . . of (i) any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with [45 CFR part 46] or the determinations of the IRB; and (ii) any suspension or termination of IRB approval.”¹²⁵

III. Training and Education:

HHC recognizes that rules and regulations relating to healthcare organizations are complex. The consequences of non-compliance, particularly in the areas of billing, reimbursement and medical record documentation, may be significant and costly. The best way to prevent non-compliant behavior is to ensure that employees know and understand the rules and how best to apply them in their day-to-day work. Not surprisingly, compliance training is required by the federal and state governments and considered to be a necessity to provide employees with the requisite knowledge and skills to carry out their responsibilities in compliance with all requirements. Accordingly, a key element of the HHC Compliance Plan is to ensure that all relevant employees, affiliates and the Board receive compliance training and education covering compliance issues, expectations of employees in creating an environment of compliance, and the operation of the HHC Compliance Program.

The OCC takes a comprehensive approach to the mandated compliance education and training, the first step of which is the training and education of OCC staff.

a. Board of Directors

Members of the Board of Directors are required to participate in State approved training regarding their legal, fiduciary, financial and ethical responsibilities as directors within one (1) year of their appointment to the Corporation.¹²⁶ Additionally, board members are required to participate in such continuing training as may be required to remain informed of best practices, regulatory and statutory changes relating to the effective oversight of the management and financial activities of public authorities and to adhere to the highest standards of responsible governance.

¹²² 45 CFR § 46.107[a]

¹²³ *Id.*

¹²⁴ 45 CFR §§ 46.103[b][4], 46.108[a]

¹²⁵ 45 CFR §§ 46.103[b][5], 46.108[a]

¹²⁶ *See* Public Authority Law § 2824[2]

b. Compliance Staff

Consistent with the responsibilities described in HHC OP 50-1, the CCO assists all compliance staff in staying current on compliance guidance, changes to applicable laws and best practices in the compliance profession. To accomplish this, the CCO provides Compliance staff with educational materials and opportunities such as webinars, videos, internal and external seminars, expert speakers, training sessions, and industry publications (e.g., books, manuals, magazines and electronic resources).

The CCO also will provide the necessary educational opportunities and resources to obtain Health Care Compliance Association, Board Certification in Health Care Compliance (“Certification”). To this end, the OCC has created an Internal Certification Pathway, which ensures that each Compliance Officer accumulates the education credits required to take the Certification exam, as well as those required for re-certification. All NCOs are required to obtain and maintain Certification.

c. Education Committee

The CCO, through methods including the creation of an education committee, (“EduCom”) ensures that compliance training and education objectives and materials are current, relevant and effective. The EduCom undertakes various education-related tasks including examining potential training opportunities and creating standardized training modules for specific disciplines such as nursing, medicine and operational areas such as finance. The CCO ensures that all education conveys HHC’s commitment to compliance and standards for integrity, the importance of complying with applicable laws and regulations, the non-retaliation policy and the various mechanisms for personnel to anonymously report potential compliance issues.

d. The OCC Intranet Website

The OCC has a Compliance website that can be accessed at the following address <http://compliance.nychhc.org/>, and which is maintained by an OCC committee, the TechCom. This website provides materials for the reference of all staff, including links to the current OIG and OMIG work plans, the HHC WorkPlan, information about federal, state and local laws, HHC compliance policies, and compliance guidance from reputable sources. Employees are able to access at their convenience training and education modules, mandatory fraud and abuse training, copies of compliance newsletters and a variety of other required and informational training and education resources. The Compliance website allows staff to have around-the-clock access to compliance policies and procedures, information about the HHC Compliance Program, and guidance on how to report potential compliance issues.

e. Training and Education Methods

The OCC develops appropriate methods to ensure that all appropriate personnel receive training and education. All reputable and relevant materials, including webinars, videos and other materials from industry organizations and entities will be considered. Any available means that can maximize the effectiveness of the training and education will be evaluated, and all possible

opportunities, such as annual HHC or facility events and department meetings, will be considered for training and education.

Written materials, such as The HHC Principles of Professional Conduct and the multi-page Guide to Compliance, shall be used whenever possible. Compliance advisory emails regarding significant legal or regulatory developments or new risk areas will be sent to affected staff, and discipline-specific newsletters will be created to provide education to targeted staff on a regular basis. Compliance staff will have handouts on important topics, e.g., the elements of the compliance program and HHC OP-50-1, to educate employees on a daily basis, and posters will be used throughout the facilities. Computer-based education modules will be used for mandated education for appropriate staff. Paycheck stuffers will be used as appropriate.

New employee training and education is provided to employees upon employment and includes education on compliance issues and expectations, the operation of the compliance program, and relevant legal requirements, including, but not limited to:

1. Federal False Claims Act as required by the Deficit Reduction Act,
2. Federal administrative remedies for false claims and statements established under 31 U.S.C. §§ 3801 – 3812,
3. State laws pertaining to civil or criminal penalties for false claims and statements,
4. Whistleblower protection under federal and state laws, and
5. HHC policies and procedures for detecting and preventing fraud and abuse.

All employees receive annual education on the Deficit Reduction Act and Fraud Waste and Abuse Prevention guidance. Computer-based training (“CBT”) on Fraud and Abuse and discipline- or department-specific compliance issues is required for all Group 11 employees (i.e., managers), all providers (including affiliates) and relevant Group 12 employees (i.e., non-managers) on an annual basis. Issue-specific education and training deriving from corrective action plans will be required for affected staff. Training shall be documented on sign-in sheets, in minutes from meetings and by electronic or manual tracking where applicable.

f. Training and Education Assessment

The OCC will re-evaluate education and training initiatives as appropriate to ensure that they are current and effective. This assessment may include a review of the current training methods including, but not limited to, videos, educational training modules (for new employees and for department-specific training), and the training and education outreach forums being utilized. The CCO will take into consideration results of investigations, legal and regulatory changes, best practices and outcomes of current training initiatives when assessing education and training modules. Relevant changes will be made, taking into consideration resources available, as soon as possible after assessments are performed.

g. Finance Training and Education

In addition to the OCC's efforts, HHC, through COF, engages in comprehensive education and training of its finance staff. To ensure that bills issued are in compliance with applicable laws and regulations, Revenue Management periodically issues inpatient, long term care and outpatient policy manuals which summarize the rules for billing, coverage, and eligibility for all third party payers. These are supplemented and amended as necessary whenever regulations or billing methodologies are revised, and are available on the HHC Intranet.

On an as-needed basis, policies and procedures related to coding, coordination of benefits, and other changes are distributed when COF is notified of such changes by third party payers. Information on these changes is shared with patient accounting, operations, medical records, and other facility administrators, in addition to holding educational seminars in conjunction with the billing vendor. All training related to billing stresses the importance of generating accurate claims that reflect the services actually provided as well as the importance of documentation to support the services on every claim.

Revenue Management has developed third party policy manuals that are available on the HHC intranet. The policy manuals and all of the billing alerts and procedures that are issued to the facility finance and ambulatory care departments are based upon rules issued to by payers through the Medicaid MMIS manuals, CMS Medlearn bulletins and website, Department of Health bulletins and website, and other regulatory bulletins.

Corporate Reimbursement holds monthly meetings with facility Reimbursement Directors to review current issues, best practices and corporate guidelines for cost reporting and other reimbursement issues. In advance of each cost report preparation period, meetings are used to review new requirements and standard work, including presentations by expert consultants. Additionally, corporate and facility staff regularly attend trainings and seminars presented by DOH, Health Finance Management Association, Greater New York Hospital Association and other industry associations. Issues raised through these forums are reviewed in COF regular meetings to address applicability to the Corporation.

The Office of Managed Care works with a consultant to provide ongoing education services on the current reimbursement and coding guidelines. To design a corporate-wide training curriculum, the consultant collects a random sample of medical records from various facilities to identify training opportunities. The reviews target medical records that have been coded and that have not been billed. The goal of chart reviews is to assess the accuracy, completeness and quality of documentation and coding. Subsequently, the consultant will conduct onsite reviews that include interviewing coding staff and assessing coding policies and procedures. These medical record/chart reviews become case studies and lay out the foundation for the training presentation.

In addition, the consultant conducts comparative analyses on HHC hospitals against its peer hospitals using applicable benchmarks and documentation/coding performance indicators. The consultant reviews external reports (e.g., CERT, OIG/OMIG Work Plans, SPARCS, and QARR) and incorporates these measures into the analyses.

The Corporation also uses Sentinel software to screen claims data through a series of coding edits. Sentinel functions as an audit tool to evaluate the accuracy of coding, billing and the quality of documentation. In addition, Sentinel has edits to identify pay-for-performance and quality issues like Present on Admission, Hospital-Acquired Conditions, Never Events and other key indicators. Sentinel generates coding worksheets for each case or claim flagged with a potential coding error. It allows the DRG validator and coder to query a physician for documentation specificity.

All this preparation work allows for a well-planned and effective training curriculum. At the training sessions, the consultant is able to provide real-time feedback with specific facility examples and clarify with physicians and coders the reimbursement and coding guidelines.

h. HIPAA Training and Education

HHC ensures that all staff understands the importance of protecting the privacy and security of patient health information. Accordingly, HHC OPs Nos. 240-16 (*HIPAA Policy on Workforce Training*) and 250-09 (*HIPAA Security Policy—HIPAA Security Awareness Training*) mandate that all HHC workforce members receive HIPAA training on the appropriate use and disclosure of PHI, patients' rights to privacy, and safeguarding PHI and EPHI. Workforce members include employees, affiliates, consultants, students and volunteers. The CPSO is responsible for the development of the HHC HIPAA training curriculum as well as the coordination and tracking of HIPAA training for all workforce members. Core HIPAA training consists of a CBT module¹²⁷ or a live stand-up training session involving the use of a CPSO-approved power-point presentation. Workforce members are considered HIPAA training-compliant when they successfully complete either the CBT or the live stand-up course.

A HIPAA training database is utilized to enroll new workforce members in the HIPAA CBT, to track their completion of HIPAA training within 60 days of the start of their employment, and to maintain the training records of the entire workforce.

Aside from the one-time HIPAA training requirement, workforce members receive supplemental training in the core principles of HIPAA compliance and/or changes in HIPAA regulations or HHC procedures via HIPAA Alerts and e-Updates. The Alerts and e-Updates are sent to members of the workforce regularly throughout the year and focus on key issues that affect HIPAA compliance. HHC networks and facilities are permitted to develop their own HIPAA training model, so long as it includes providing for workforce members to take either of the two CPSO-approved core curriculum options. Many networks and facilities choose to incorporate HIPAA policies and procedures into their annual in-service training that, along with the Alerts and e-Updates, help reinforce our compliance standards.

¹²⁷ Workforce members are encouraged to contact the Enterprise Service Desk ("ESD") when reporting technical issues with the CBT. The ESD often resolves the issue without the need for further escalation, but occasionally forwards the issue to the CPSO group for resolution. The CPSO also receives requests for technical assistance via the HIPAA.CBL@nychhc.org account.

IV. Communication Lines to the CCO:

HHC understands that its employees are often best situated to identify issues that can give rise to compliance concerns. Accordingly, HHC encourages all employees to report any concerns to a supervisor or the CCO without fear of retaliation. To maximize the opportunity for employees to report those issues, HHC is committed to establishing and maintaining communication lines to the CCO and insuring that they are accessible to all employees, persons associated with the hospital, executives, and the Board.

The key communication line to the CCO is the Compliance Help Line: 1-866-HELP HHC, a toll-free line operated by a vendor. Any call to the line will be answered by a live operator, as the line is staffed 24 hours a day, 365 days a year. The call is logged by the vendor and forwarded to the CCO, who then tracks it through resolution.

The existence of the Help Line, its number and the availability of anonymous reporting is emphasized at new employee orientation and all OCC training and education. The Help Line information, as well as the CCO's contact information, can be found in, among other places, on the HHC Principles of Professional Conduct, the Guide to Compliance, posters, newsletters, in HHC OP 50-1, on the intranet, and as part of the email signature line of all Compliance staff.

Employees can also call, write or visit the CCO's office, as well as any of the offices of other Compliance Officers located at each network to report any compliance concerns.

OCC also makes available a Fraud and Abuse Form ("Form") that can be used to anonymously report a compliance concern. The Form is available in paper outside of the offices of Compliance Officers, and can be accessed and submitted electronically through the OCC intranet site.

The Compliance Program will periodically assess the available communication lines to increase their effectiveness.

V. Disciplinary Policies:

HHC is committed to ensuring that there is uniform practices for enforcement and discipline for individuals at all levels of the organization who fail to comply with all federal and state laws, regulations, guidelines and policies. Those who fail to comply with applicable laws and policies will face "disciplinary action and/or sanction."¹²⁸ Further, "[s]upervisors and/or managers can be held accountable for the foreseeable compliance failures of their subordinates."¹²⁹

All members of the HHC workforce are encouraged to report violations promptly to the office of the CCO. "All reported violations, including allegations of intimidation or retaliation, will be fully and completely investigated, and appropriate steps will be taken to remedy the situation. All members of the HHC workforce must participate and/or cooperate in good faith with any

¹²⁸ OP 50-1, § [9]

¹²⁹ *Id.*

investigation into a reported violation, be truthful with investigators and preserve documentation and/or records relevant to ongoing investigations.”¹³⁰

Moreover, “[f]ailure to report a violation, participate or cooperate with an investigation, be truthful with investigators, preserve documentation and/or records relevant to ongoing investigations, as well as participating in non-compliant behavior or encouraging, directing, facilitating or permitting non-compliant behavior will result in disciplinary action and/or sanction” including “written warnings suspension and/or termination of employment or contract with HHC.”¹³¹ In the event disciplinary actions and/or sanctions are warranted, the CCO will coordinate its efforts with each Network's or Facility's Human Resources and/or Labor Relations Department.¹³²

VI. Identification of Compliance Risk Areas:

As outlined in 18 NYCRR § 521.3 - Compliance Program Required Provider Duties, HHC is mandated to have a compliance program which has “a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries[.]”¹³³

In practical terms, this means that HHC must determine which HHC processes are at high risk for non-compliance and then prioritize those high risk processes into an annual WorkPlan. The annual WorkPlan will outline the expected work activities of the HHC Office of Corporate Compliance (OCC) for the fiscal year.

HHC recognizes that the hundreds of thousands of complex operations occurring throughout its facilities on a daily basis can give rise to weaknesses in internal controls, and is ever vigilant in identifying those areas before issues materialize. This proactive approach is consistent with that recommended by state and federal regulators who note in their respective compliance guidance that an ongoing process for identifying risks, evaluating those risks through auditing and data analysis, and creating and implementing remedial measures to identified issues is critical to an effective compliance program.

In an effort to focus resources and activities, the OCC utilized previously released annual work plans by the Office of Inspector General (OIG) and the Office of the Medicaid Inspector General (OMIG) to identify areas to be assessed for risk. Compliance staff looked to these sources, as general guides when identifying areas for risk assessment. The risk assessment was carried out in three modalities; web-based confidential questionnaires; staff interviews; and documentation review (e.g. minutes, enforcement actions, etc...).

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ 18 N.Y.C.R.R. § 521.3[c][6]

Corporate Compliance Plan

Web-based Risk Assessment Activities: HHC utilizes an internet based software application that to assess compliance-related processes and identify areas of risk. This web based modality allows the OCC to survey staff utilizing logic based questionnaires. By using an electronic format, the OCC can receive input from line staff which is more intimately involved in the processes being evaluated.

Documentation Review based Risk Assessment Activities: In order to identify additional risk areas not listed in the OMIG/OIG work plans), OCC staff review external documents, (e.g. Fraud Alerts, enforcement actions, regulatory and industry publications) as well as internal documents (e.g. Audit Findings, oversight committee minutes, inspection results from external agencies, complaint reports).

Interview based Risk Assessment Activities: OCC staff conducts interviews with all levels of staff, from line workers to senior management. Interview questions and logic are specific to the area being assessed. Face to face interviews allow staff to gain a thorough understanding of the operational characteristics of the risk area being assessed. This modality allows staff to provide supporting documents and clarify risk assessment objectives. Additionally, it provides an opportunity for OCC staff to provide face to face education to employees in high risk areas.

Prioritization of Risk Areas: HHC's approach to creating the WorkPlan involved reviewing issues identified through the enterprise-wide risk assessment and assigning them to one of three categories. (Please see attached Grid) This stratification will ensure that the WorkPlan addresses issues identified as risks for the entire corporation and key networks, while maintaining sufficient flexibility to address issues as they arise. All items, whether corporate or network, will be reported to the Board of Directors on a regular basis. The stratifications are:

- *High Risk Items* – Issues deemed “High Risk” (i.e. high volume/high impact/low detectability) to the corporation. All High Risk items will be reviewed in all networks. These items will be reported to the Board of Directors
- *Medium/Low Risk Items (Network Items)* – These issues were identified as having “Medium” to “Low” risk. These items may be specific to certain networks. Each network will work on these issues as well as those identified as corporate items.
- *Ad Hoc Items* – Issues identified by audits, informational requests from external agencies, enforcements actions, changed or new laws /regulations, etc... These items will be added to the WorkPlan as they are identified.

Planning and Review Process: The Corporate Compliance Officer will develop mitigation and monitoring plans, and, where deemed necessary on a case-by-case basis, post-closure review plans, for each item on the WorkPlan and ensure appropriate resources are allocated.

Once a mitigation plan is developed and implemented, the items on the WorkPlan will be systematically monitored and, as needed, audited for compliance. Reviews at a minimum will include identification of best practices, staff education, and post improvement monitoring.

When the monitoring of an implemented mitigation plan discloses program deficiencies, appropriate corrective action measures will be implemented as soon as possible. Any errors or overpayments discovered as a result of the ongoing auditing and monitoring will result in the prompt return of any overpayment, with appropriate documentation and a thorough explanation of the reason for the refund.

Additionally, some closed items will require post-closure review monitoring at set time horizons. Post-closure reviews will be performed on a case-by-case basis based on level of risk present, the magnitude of closed risk items, the availability of compliance resources, the nature and complexity of the controls and policies implemented, the audit activities of OIG, OMIG and other regulators, any other factor that good sound judgment would require be considered.

It should be noted that the CCO also continues to have compliance responsibility for items included in WorkPlans for prior periods, including, for example, billing Medicaid for drugs purchased under the 340B Program; Medicaid payments for deceased individuals; and coordination of responses to investigations and enforcement actions under federal, state, and local environmental protection programs.

VII. Responding to Compliance Issues:

HHC strives to maintain an effective Compliance Program, and has accordingly established several lines of communication to the CCO for employees and others to raise compliance issues. To appropriately handle those issues when raised, the OCC has put into place the necessary procedures to resolve all levels of potential compliance questions or concerns.

a. The Unified Compliance Index

The OCC employs a systematic procedure for documenting and tracking all concerns reported to the OCC. The procedure ensures that all compliance contacts, including, but not limited to, letters, emails, in-person complaints, Help Line calls and other departmental referrals are documented in the Unified Compliance Index (“UCI”). The UCI is maintained centrally, and facilitates tracking contacts for timeliness of action and ultimate resolution.

b. The Review Process

If a high severity issue – one that could affect the safety or health of any patient, staff, or person – is reported, the CCO will act immediately to ensure that the report is investigated and resolved as soon as possible. When a compliance contact references an issue outside of the purview of the OCC, that matter will be referred in a timely manner to the relevant area. The OCC will follow up on every such matter to assure that it was resolved. All such dispositions will be logged in the UCI.

When a compliance contact references a potential compliance issue, the OCC will ensure all issues are fairly and thoroughly reviewed. All such reviews will be managed by the CCO with site investigation conducted by the OCC staff assigned to the relevant network. When warranted, the OCC will utilize resources outside the OCC, such as the IG, OIA or non-HHC

consultants, to aid in the investigation. The OCC will hold itself and the entire organization to the highest level of ethical integrity and ensure that all investigations are free from any potential or actual conflicts of interest. Ultimately, an appropriate conclusion will be made regarding whether or not an actual compliance issue or instance of misconduct occurred.

For each investigation conducted, an investigative report, utilizing the Investigation Summary Template (“IST”), will be used to summarize the results of the investigation. All original contact information, the investigative file and the IST shall be confidentially maintained by the OCC for a period of 6 years.

c. Resolution

The CCO will work with the relevant managers to determine the appropriate course of action. The CCO will ensure that corrective actions, which may include the creation or revision of procedures, policies, or systems necessary to reduce the potential for recurrence of identified compliance problems, are monitored to verify that the issue is addressed and long-term best practices are implemented and operating effectively. If warranted, training modules will be developed and relevant staff will be educated.

When an inappropriate payment is discovered, relevant activity will be stopped as appropriate and the affected regulator will be contacted to arrange for return of monies not entitled to the Corporation or to discuss the terms of a voluntary self-disclosure. When warranted, the CCO will advise the President and/or Audit Committee of potential compliance issues.

When the disciplinary process is to be utilized, HHC is committed to ensuring that there is a uniform practice for enforcement and discipline for individuals at all levels of the organizations who fail to comply with any federal or state law, regulation, guideline or policy. All individuals, regardless of position, who fail to comply, will receive discipline consistent with and appropriate to the specific circumstances involved.


VII. Prohibition of Intimidation or Retaliation:

HHC will not take any retaliatory action against an employee if the employee discloses certain information about the HHC’s policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee’s disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. This protection is extended to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment.


Corporate Compliance Plan

Corporate Compliance Plan Submitted By:

Approved By:



Wayne A. McNulty, JD, CHC
Corporate Compliance Officer



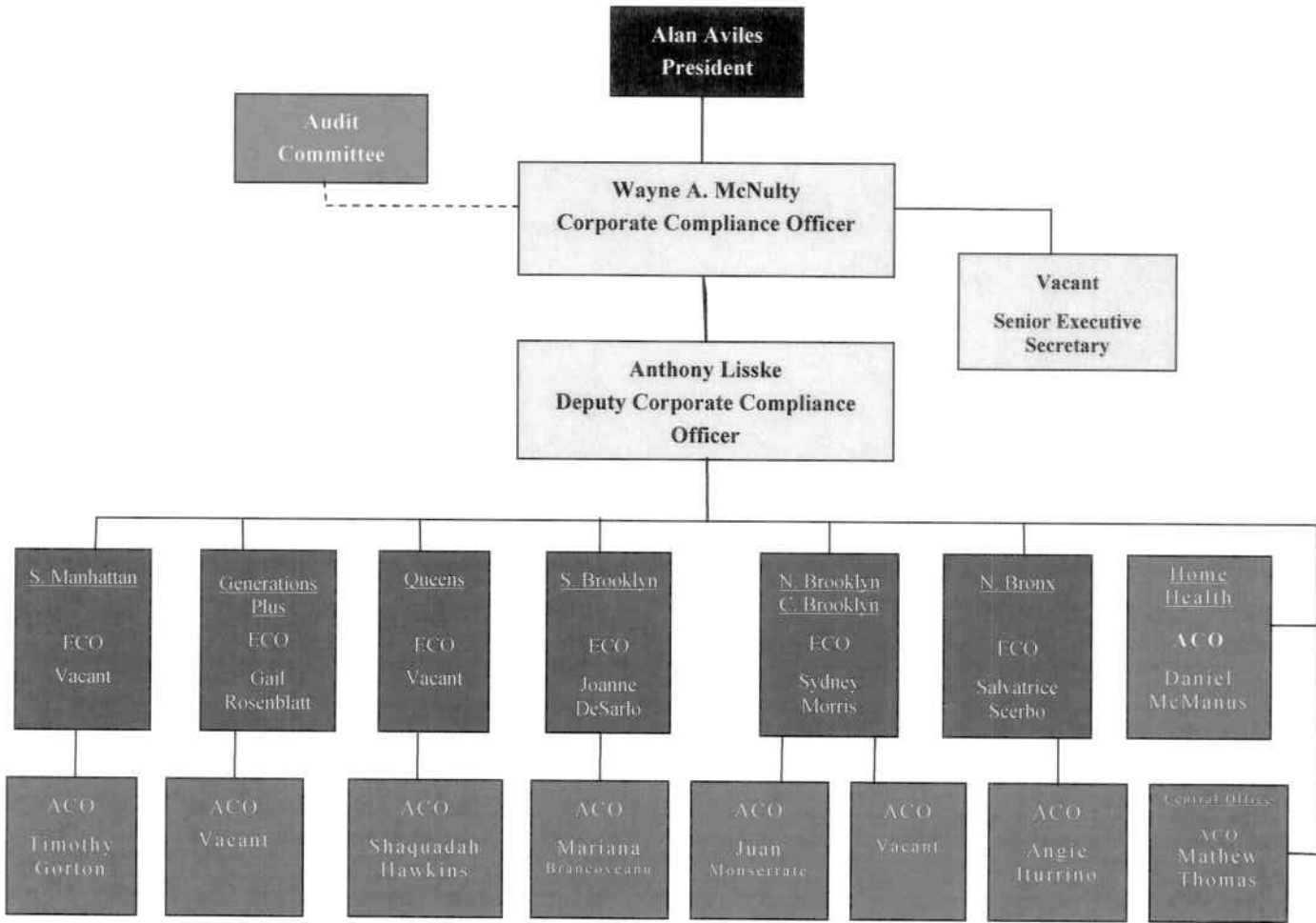
Alan D. Aviles, JD
President & Chief Executive

Date: 11/9/11

Date: 11/9/11

Appendix A. Office of Corporate Compliance – 2011 Table of Organization

As of 10/21/11



Appendix B: Glossary of Coined Terms

Assessment	Self-Directed HIPAA Privacy Assessments
BA	Business Associates
BAA	Business Associate Agreement
Board	Board of Directors
CCO	Corporate Compliance Officer
CBT	Computer-based training
CDM	Charge Description Master
Certification	Board Certification in Health Care Compliance
COF	Central Office Finance
Corporation	New York City Health and Hospitals Corporation
CPSO	Corporate HIPAA Privacy and Security Office
DOH	Department of Health
ECW	Executive Compliance Workgroup
EduCom	Education committee
EPHI	Electronic Protected Health Information
FCA	False Claims Act
Form	Fraud and Abuse Form
FPO	Facility Privacy Officer
HHC	New York City Health and Hospitals Corporation
HHC Code of Ethics	Code of Ethics of the New York City Health and Hospitals Corporation
HIPAA	Health Insurance Portability and Accountability Act
HRA	Human Resources Administration
IG	Inspector General
IRB	Institutional Review Board
IS	Corporate Office of Information Services
IST	Investigation Summary Template
NCC	Network Compliance Committee
NCO	Network Compliance Officer
NPP	Notice of Privacy Practices
NSO	Network Security Officer
NYC Conflicts of Interest Law	Chapter 68 of the City Charter
NYSFCA	New York State False Claims Act
OCC	Office of Corporate Compliance
OHRP	United States Department of Health and Human Services
OIA	Office of Human Research Protections
OLA	Office of Internal Audits
OP	Office of Legal Affairs
PHI	Operating Procedure
Plan	Protected Health Information
UCI	Corporate Compliance Plan
WorkPlan	Unified Compliance Index
	HHC Annual Compliance Work Plan

Appendix C - Overview of Applicable Laws and Codes

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS¹³⁴

I. FEDERAL LAWS

- 1) Federal False Claims Act (31 USC §§3729-3733)

II. NEW YORK STATE LAWS

A. CIVIL AND ADMINISTRATIVE LAWS

- 1) New York False Claims Act (State Finance Law §§187-194)
- 2) Social Services Law, Section 145-b - False Statements
- 3) Social Services Law, Section 145-c - Sanctions

B. CRIMINAL LAWS

- 1) Social Services Law, Section 145 - Penalties
- 2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.
- 3) Social Services Law, Section 145-c - Sanctions
- 4) Penal Law Article 175 - False Written Statements
- 5) Penal Law Article 176 - Insurance Fraud
- 6) Penal Law Article 177 - Health Care Fraud

III. WHISTLEBLOWER PROTECTION

- 1) Federal False Claims Act (31 U.S.C. §3730(h))
- 2) New York State False Claim Act (State Finance Law §191)
- 3) New York State Labor Law, Section 740
- 4) New York State Labor Law, Section 741

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, as follows:

§ 3729. False claims

(a) Liability for certain acts.--

2) In general.--Subject to paragraph (2), any person who--

- (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
- (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);
- (D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
- (E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government,

¹³⁴ Pages 43 to 50 of this Plan are duplicated from the website of the New York State Office of the Medicaid Inspector General, Compliance, Certification, Federal Deficit Reduction Act, Relevant Statutes, accessed at http://www.omig.ny.gov/data/images/stories/relevant_fca_statutes_122209.pdf

- makes or delivers the receipt without completely knowing that the information on the receipt is true;
- (F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
 - (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461) note; Public Law 104-410, plus 3 times the amount of damages which the Government sustains because of the act of that person.
- (2) Reduced damages.--If the court finds that--
- (A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;
 - (B) such person fully cooperated with any Government investigation of such violation; and
 - (C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.
- (3) Costs of civil actions.--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.
- (b) Definitions.--For purposes of this section--
- (1) the terms "knowing" and "knowingly" --
 - (A) mean that a person, with respect to information--
 - (i) has actual knowledge of the information;
 - (ii) acts in deliberate ignorance of the truth or falsity of the information; or
 - (iii) acts in reckless disregard of the truth or falsity of the information; and
 - (B) require no proof of specific intent to defraud;
 - (2) the term "claim"--
 - (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that--
 - (i) is presented to an officer, employee, or agent of the United States; or
 - (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to

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advance a Government program or interest, and if the United States Government-

- (I) provides or has provided any portion of the money or property requested or demanded; or
- (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
- (B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;
- (3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and
- (4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.
- (c) Exemption from disclosure.--Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.
- (d) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds, that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital which obtains interim payments from Medicare or Medicaid throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "qui tam relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not

more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

3) Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801 – 3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, the agency receiving the claim may impose a penalty of up to \$5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK STATE LAWS

New York State False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

A. CIVIL AND ADMINISTRATIVE LAWS

1) New York False Claims Act (State Finance Law §§187-194)

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with

payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, Section 145-b - False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

3) Social Services Law, Section 145-c - Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. CRIMINAL LAWS

1) Social Services Law, Section 145 - Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2) Social Services Law, Section 366-b - Penalties for Fraudulent Practices.

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a class A misdemeanor.

b. Any person who, with intent to defraud, presents for payment a false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a class A misdemeanor.

3) Penal Law Article 155 - Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. This statute has been applied to Medicaid fraud cases.

- a. Fourth degree grand larceny involves property valued over \$1,000. It is a class E felony.

- b. Third degree grand larceny involves property valued over \$3,000. It is a class D felony.
- c. Second degree grand larceny involves property valued over \$50,000. It is a class C felony.
- d. First degree grand larceny involves property valued over \$1 million. It is a class B felony.

4) Penal Law Article 175 - False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

- a. §175.05 - Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a class A misdemeanor.
- b. §175.10 - Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a class E felony.
- c. §175.30 - Offering a false instrument for filing in the second degree involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information. It is a class A misdemeanor.
- d. §175.35 - Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a class E felony.

5) Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, including Medicaid or other health insurance, and contains six crimes

- a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a class A misdemeanor.
- b. Insurance fraud in the 4th degree is filing a false insurance claim for over \$1,000. It is a class E felony.
- c. Insurance fraud in the 3rd degree is filing a false insurance claim for over \$3,000. It is a class D felony.
- d. Insurance fraud in the 2nd degree is filing a false insurance claim for over \$50,000. It is a class C felony.
- e. Insurance fraud in the 1st degree is filing a false insurance claim for over \$1 million. It is a class B felony.
- f. Aggravated insurance fraud is committing insurance fraud more than once. It is a class D felony.

6) Penal Law Article 177 - Health Care Fraud

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute.

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

- a. Health care fraud in the 5th degree – a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan. This is a class A misdemeanor.
- b. Health care fraud in the 4th degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars. This is a class E felony.
- c. Health care fraud in the 3rd degree – a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars. This is a class D felony.
- d. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars. This is a class C felony.
- e. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars. This is a class B felony.

III. WHISTLEBLOWER PROTECTION

1) Federal False Claims Act (31 U.S.C. §3730(h))

The Federal False Claims Act provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

2) New York State False Claim Act (State Finance Law §191)

The New York State False Claim Act also provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

3) New York State Labor Law, Section 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

4) New York State Labor Law, Section 741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.