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Operating Procedure 50-1¹

CORPORATE COMPLIANCE AND ETHICS PROGRAM

TO: All NYC Health + Hospitals Workforce Members
All NYC Health + Hospitals Business Partners
All NYC Health + Hospitals Agents
Distribution “E”²

FROM: Stanley Brezenoff
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DATE: January 5, 2018

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¹ This Operating Procedure (“OP” or “Policy”) supersedes and replaces OP 50-1 (Corporate Compliance Program) dated October 29, 2009, and any subsequent changes thereto, in its entirety. As set forth in § 29 [Ongoing Review of Policy] of this OP, *infra*, the NYC Health + Hospitals Chief Corporate Compliance Officer shall be responsible for the periodic review of this OP, as well as documentation of such review.

² See Operating Procedure 10-11 for the titles of the individuals covered under Distribution “E.”

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Attachments

ATTACHMENT I

NYC Health + Hospitals Corporate Compliance and Ethics Program – Summary of Workforce Member, Business Partner, and Agent Responsibilities.

ATTACHMENT II

An Overview of Operating Procedure 50-1 – NYC Health + Hospitals Corporate Compliance and Ethics Program: A Roadmap to Assist Workforce Members, Business Partners, and Agents to understand their Responsibilities and Obligations under OP 50-1.

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1. INTRODUCTION

A. Overview

This Operating Procedure (hereinafter referred to as “OP” or “Policy”):

- (i) Governs how the NYC Health + Hospitals (hereinafter also referred to as the “System”)³ Corporate Compliance and Ethics Program (hereinafter the “Program”) is to be implemented, managed, enforced, monitored, and otherwise operated; and
- (ii) Outlines the roles and responsibilities of, and the procedures that must be followed by, each Covered Person, as that term is defined in § 6 [**Applicability**], *infra*, to meet their obligation to affirmatively participate in the Program.⁴

B. How do I know if I am subject to this OP?

If you fall into any one of the following three categories of Covered Persons, then you are subject to this OP and are required to comply with the same:

- (i) Workforce Members;
- (ii) Business Partners; or
- (iii) Agents.

Note that, the definition of each of the above terms is defined below in § 6 [**Applicability**].

C. If I determine that I am a Covered Person and therefore subject to this OP, what are my responsibilities under this OP?

All Covered Persons are responsible for affirmatively participating in the Program as described in detail under § 12 [**Responsibilities of All Covered Persons**], *infra*. In addition to these requirements, certain Workforce Members have further responsibilities under this OP.

³ Throughout this Policy the terms “NYC Health + Hospitals” and the “System” are used interchangeably. Both of these terms as used herein shall mean the New York City Health and Hospitals Corporation, a public benefit corporation created pursuant to McKinney’s New York Unconsolidated Law § 7381 *et seq.*, and includes all facilities, units, and entities described in § 5 [**Scope**], *infra*, of this Policy.

⁴ Covered Persons are advised to pay particular attention to § 12 [**Responsibilities of All Covered Persons**], *infra*, which provides a key overview of their responsibilities under the Program.

For example, Workforce Members that serve on the various System compliance committees, as well as Workforce Members within the Office of Corporate Compliance (“OCC”), executive administration, and supply chain, have additional responsibilities as outlined below, respectively:

- (i) Section 11 – **Establishment of Compliance Committees**
 - (ii) Section 13 - **Responsibilities of the CCO and other Compliance Personnel**
 - (iii) Section 14 - **Procedures of the CCO and Other Compliance Personnel**
 - (iv) Section 16 – **Executive Administrative Oversight Responsibilities**
 - (v) Section 20 – **Contract Requirements**
- D. Is there a brief guide that outlines my responsibilities under the Program or a roadmap summary of this OP that I can follow to help me further understand my compliance obligations under this OP?

The answer is **YES** to both questions.

Specifically, annexed to this OP as Attachment I, is the *NYC Health + Hospitals Corporate Compliance Ethics Program – Summary of Workforce Member, Business Partner, and Agent Responsibilities* (the “Summary of Responsibilities”). The Summary of Responsibilities provides a one page (back and front) overview of the responsibilities of Covered Persons under the Corporate Compliance and Ethics Program. Further, Attachment II of this OP - - *An Overview of Operating Procedure 50-1 – Corporate Compliance and Ethics Program: A Roadmap to Assist Workforce Members, Business Partners, and Agents to understand their Responsibilities and Obligations under OP 50-1* (the “Road Map”) - - is a PowerPoint presentation that serves as a summary educational tool and roadmap for Covered Persons to utilize to understand their responsibilities under OP 50-1.

All Covered Persons are encouraged to read the aforementioned Attachments, along with the other attachments listed in § 7 [**Attachments**], *infra*, to assist their navigation through this OP and to help them understand their obligations under the Program.

- E. I have read both Attachments I and II - - do I need to read the remainder of this OP?

YES – The one page *Summary of Responsibilities* and the *Roadmap* PowerPoint are for guidance purposes only and are not intended to replace OP 50-1. Rather, they should be read in conjunction with the specific provisions of this OP. The main purpose of both Attachments I and II is to clarify, summarize, and to an extent, implement the provisions of OP 50-1, not to replace the same.

2-a. “COMPLIANCE” AND “ETHICS” DEFINED

A. Compliance

Compliance is an organizational culture that fosters the prevention, detection, and resolution of conduct that fails to comply with applicable law and/or an organization’s own ethical and business policies.⁵ The System is committed to a culture of compliance and it expects all Covered Persons to conduct themselves in manner that is consistent with this commitment.

B. Ethics

In a nutshell, “Ethics” is *doing the right thing*.⁶ The System is committed to ethical conduct and expects all Covered Persons to conduct themselves in an ethical and legal manner.⁷ Examples of ethical conduct include the following:

- (i) Acting fairly and honestly;⁸
- (ii) Complying with standards of conduct that articulate an organization’s commitment to comply with applicable law and outline its ethical requirements of compliance;⁹
- (iii) Complying with all applicable legal requirements including, without limitation, fraud, waste, and abuse laws (*see* § 2-b, [**What do the Terms “Fraud”, “Waste” and “Abuse” Mean?**], *infra*);¹⁰

⁵ See e.g., Department of Health and Human Services Office of Inspector General (“OIG”), *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8988, § [I] (1998).

⁶ CMS Medicare Learning Network, Medicare Parts C and D General Compliance Training Web-Based Training Course, Lesson Page 7- *Ethics -Do the Right Thing!*, p.17 [January 2017], available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf>

⁷ See *id.*

⁸ See *id.*

⁹ See e.g., 63 Fed. Reg. at 8987, 8989-90, § [II][A][1] (1998); see also OIG, *OIG Supplemental Compliance Program Guidance for Hospitals*, 70 Fed. Reg. 4858, 4874, § [III][A] (2005).

¹⁰ See 63 Fed. Reg. at 8987, 8990, § [II][A][2] at note 10 (1998) (highlighting that compliance with fraud, waste and abuse laws is an ethical area that should be part of Workforce Member training).

- (iv) Following applicable industry practices that are lawful, fair, and non-deceptive in nature;¹¹
- (v) Adherence by professionals to applicable ethical standards of conduct dictated by their respective professional organizations;¹²
- (vi) Reporting compliance violations (“Compliance Reporting”); and
- (vii) Enforcing disciplinary policies.¹³

2-b. WHAT DO THE TERMS “FRAUD”, “WASTE” AND “ABUSE” MEAN?

The terms fraud, waste and abuse may have various technical definitions under numerous laws and regulations. If you have any questions or concerns related to the meaning of these terms, please contact the OCC (as provided below in subdivision “B” of § 22 [**Mandatory Reporting and Compliance with Investigations**]) for clarification. As an example, under the footnoted authorities, these terms are defined as follows:

A. Fraud

Fraud is an intentional deception or misrepresentation made with the knowledge that the deception/misrepresentation could result in some unauthorized benefit to the individual or entity making such deception/misrepresentation or someone else.¹⁴

B. Waste

Waste is the overuse of services or other practices that, directly or indirectly, results in unnecessary costs to a Federal healthcare program (*e.g.*, Medicare, Medicaid, and Tricare). Generally, waste is not the result of criminally negligent actions, but rather an end product of the misuse of resources.¹⁵

¹¹ See, generally, United States Sentencing Commission Guidelines Manual (2016) (“FSG”), § 8B2.1, Commentary at ¶ [2][A][i].

¹² See *e.g.*, OIG, *OIG Supplemental Compliance Program Guidance for Hospitals*, 70 Fed. Reg. 4858, 4874, § [III][A] (2005)(stating, in pertinent part, that professionals should be required to “follow the ethical standards dictated by their respective professional organizations.”).

¹³ See *e.g.*, 70 Fed. Reg. 4858, 4876, § [III][B][7] (2005)(providing that “[b]y enforcing disciplinary standards hospitals help create an organizational culture that emphasizes ethical behavior.”).

¹⁴ See 18 NYCRR § 515.1 [b][7]; 42 CFR § 455.2.

¹⁵ See CMS Combatting Medicare Parts C & D Fraud, Waste and Abuse Web-Based Training Course, rev. 1/17 (“CMS Training”), Lesson 1 Page 3 (“L1P3”), pg. 14, available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf>

C. Abuse

Abuse is any action that may directly or indirectly result in an unnecessary cost to a Federal healthcare program and involves payments for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.¹⁶

Note: Attachment III (*Operating Procedure 50-1 – Corporate Compliance and Ethics Program, Understanding the Terms Fraud, Waste, and Abuse*) of this Policy further defines the terms *fraud*, *waste*, and *abuse* and provides examples for each of these terms.

3. POLICY

It is the Policy of the System to establish, monitor, and maintain an effective Program centered on:

- A. Ensuring that the System’s operations and business practices are conducted in a manner that:
 - (i) Complies with all Federal and New York State (“State”) laws¹⁷; and
 - (ii) Represents the System’s commitment to maintain its status as a reliable, honest, and trustworthy healthcare provider;¹⁸
- B. Identifying and eliminating fraud, waste and abuse;
- C. Assessing, prioritizing and mitigating System-wide risks; and
- D. Promoting and fostering a climate of ethical conduct and good governance.

4. PURPOSE

The Purpose of the Program is to:

- A. Focus on the prevention, detection, and correction of any departure from the System's legal, regulatory, professional, fiduciary, and ethical obligations, especially as they relate to the following:
 - (i) Fraud, waste, and abuse including, without limitation, activities related to:
 - (a) Financial transactions;

¹⁶ *Id.*

¹⁷ For purposes of this OP: (i) New York State law includes applicable local law; and (ii) the term “law(s)” collectively includes all applicable Federal and State criminal, civil, and administrative laws, codes, rules, and regulations.

¹⁸ *See, generally*, 63 Fed. Reg. 8987, 8995 (1998), § [II][E][1].

- (b) Coding;
 - (c) Billing and claims submissions;¹⁹
 - (d) Claims reimbursement and payments; and
 - (e) Cost reporting;²⁰
 - (ii) Federal healthcare program conditions of participation, as well as private payor requirements;
 - (iii) Information governance;²¹
 - (iv) Risk identification, assessment, and prioritization;²²
 - (v) Corporate governance;²³ and
 - (vi) The establishment and monitoring of effective internal controls.²⁴
- B. Under the direction of the Chief Corporate Compliance Officer (“CCO”) within the Office of Corporate Compliance (“OCC”), serve as:
- (i) An established resource within the System to:
 - (a) Proactively identify and address System-wide compliance issues and concerns; and
 - (b) Exercise due diligence to deter fraud, waste and abuse, as well as unprofessional, unethical, and criminal conduct.
 - (ii) The foundation of an organizational culture that, through the implementation of practices, procedures and controls, promotes the prevention, detection, and resolution of conduct that fails to meet the requirements of:
 - (a) Applicable Federal and State law;

¹⁹ See e.g., 70 Fed. Reg. 4858, 4859-4862 (2005), § [II][A].

²⁰ See, e.g., 63 Fed. Reg. 8987, 8990 (1998), § [II][A][2].

²¹ See, generally, 8 NYCRR Part 185; see also 45 C.F.R. Part 164, Subparts C [Security Standards for the Protection of Electronic Protected Health Information] & E [Privacy of Individually Identifiable Health Information]; see also, generally, 42 CFR 482.24 [b]; 42 CFR § 2.16; 10 NYCRR §§ 405.10, 415.22 & 415.30.

²² See Social Services Law § 363-d [2][f]; 18 NYCRR §§ 521.3[a][7], [c][6].

²³ See Public Authorities Law § 2824 [1][a]; 18 NYCRR § 521.3 [a][4].

²⁴ See 63 Fed. Reg. 8987 [stating that hospitals “develop effective internal controls that promote adherence to applicable Federal and State law, and the program requirements of Federal, State and private health plans.”]; see also Public Authorities Law § 2824 [1][b].

- (b) Applicable Federal healthcare program (*e.g.*, Medicare, Medicaid, and TriCare) requirements, as well as the requirements of private payors; and
- (c) The System’s own internal policies, business practices, and ethical standards of conduct,²⁵
- (iii) An outline of the compliance process and the System’s commitment to successfully implement the same,²⁶ and
- (iv) “[A] structural foundation from which [the System] may self-police its own conduct.”²⁷

5. SCOPE

This OP governs compliance oversight activities at all NYC Health + Hospitals facilities, units, and entities including, without limitation:

- A. All acute care facilities and associated extension clinics;
- B. All diagnostic and treatment centers (“D&TCs”) (including, without limitation, those designated as Federally Qualified Health Centers (“FQHCs”) and associated extension clinics;
- C. All long-term acute care facilities and nursing homes;
- D. NYC Health + Hospitals/At Home (“At Home”); and
- E. All subsidiary corporations.

6. APPLICABILITY

This OP applies to all *Workforce Members*, *Business Partners*, and *Agents* (collectively referred to herein as “Covered Persons”) as defined below:

A. Workforce Member

For purposes of this OP, the term “Workforce Member” shall mean any of the following System individuals, whether serving in a temporary or permanent capacity on the System’s premises or remotely, who perform System duties, functions or activities on a full-time, part-time, or *per diem* basis:

- (i) Employees;

²⁵ See FSG at § 8b2.1[a][2].

²⁶ See 63 Fed. Reg. at 8988.

²⁷ FSG at Chapter Eight, Sentencing of Organizations [“Introductory Commentary”], p. 525.

- (ii) Executives;
- (iii) Affiliate employees²⁸;
- (iv) Members of the medical staff;
- (v) Members of the NYC Health + Hospitals Board of Directors and their designee agents (hereinafter also referred to as the “Board” or the “Governing Body”);
- (vi) Directors of NYC Health + Hospitals wholly owned subsidiaries;
- (vii) Members of the Gotham Health FQHC Inc. (NYC Health + Hospitals/Gotham Health” or “Gotham Health”), Board of Directors;
- (viii) Personnel;
- (ix) Appointees;
- (x) Interns;
- (xi) Trainees;
- (xii) Students;
- (xiii) Volunteers; and
- (xiv) Any individual whose conduct, in the performance of work functions and duties on behalf of the System, is under the direct control of the System, whether or not he/she is paid by the System.

B. Business Partner

For purposes of this OP, the term “Business Partner” shall mean any non-Workforce Member contractor, subcontractor, vendor or other third-party (collectively “Third Party”) that is required by law or contract (*see* § 20 [**Contract Requirements**], *infra*) to comply with this OP including, without limitation, the following Third Parties:

- (i) Any Third Party that, in acting on behalf of or otherwise being associated with NYC Health + Hospitals,²⁹ engages in activities, functions, and duties that:

²⁸ The term “affiliate employees” shall mean all affiliate employees and other affiliate personnel who, pursuant to an affiliation agreement with the System, serve as *Contract Service Providers* and perform on behalf of the System *Contract Services*, as both of these italicized terms are defined under such corresponding affiliation agreement.

²⁹ *See* 18 NYCRR § 521.3 [c][3]; *see also* New York State Office of the Medicaid Inspector General (“OMIG”) Compliance Program Review Guidance – *New York State Social Services Law Section 363-d and Title 18 New York*

- (a) Contribute to the System’s entitlement to receive payment from Federal healthcare programs or private payors³⁰ including, for example, those Third Parties that deliver, furnish, prescribe, direct, order or otherwise provide healthcare items and/or services;³¹
- (b) May place the System in a position to commit significant noncompliance with Federal health care program or private payor requirements or fraud, waste and abuse prohibitions³² including, for example, those Third Parties that:
 - Provide billing or coding functions;³³
 - Monitor the healthcare provided by the System;³⁴
 - Establish and administer:³⁵
 - The formulary of the System;
 - Medical benefit coverage policies and procedures;
 - Review beneficiary claims and services submitted for payment to Federal healthcare programs or private payors;³⁶ or
 - Exercise decision making authority (e.g., clinical decisions, coverage determinations, appeals and grievances, health plan enrollment/disenrollment functions, the processing of

Codes, Rules and Regulations Part 521 Compliance Program Review Guidance (Oct. 26, 2016) (hereinafter “OMIG Compliance Program Review Guidance”) at p. 5 (Guidance: All Affected Individuals) available at: https://omig.ny.gov/images/stories/compliance/compliance_program_review_guidance.pdf; OMIG *DRA Certification* (rev. Dec. 1, 2016), available at: <https://www.omig.ny.gov/dra-certification> (highlighting that the System’s employees, management, contractors, and agents must be informed of the System’s policies on fraud, waste, and abuse).

³⁰ See OMIG Compliance Program Review Guidance at p. 3 (Definitions: Affected Individuals).

³¹ See OMIG *FAQs Federal Deficit Reduction Act*, Section A – Program FAQs (rev. Dec. 1, 2016) at A-2 § (1)(b), available at: https://www.omig.ny.gov/images/stories/provider_compliance/dra_faqs.pdf#page=2

³² See CMS Additional Guidance – *Compliance Program Training Requirements and Audit Process Update*, p. 3 [February 16, 2016], available at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2016_Compliance_and_-FWA_Training_Requirement_Update.pdf.

³³ Centers for Medicare and Medicaid Services (“CMS”) *DRA 6032 – Employee Education About False Claims Recovery – Frequently Asked Questions* (March, 20, 2007), FAQ # 23, p. 6 of 16, available at: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD032207Att1.PDF>.

³⁴ See *id.*

³⁵ See *id.*

³⁶ See *id.*

pharmacy or medical claims) in administration of Federal healthcare programs or private payor health plans³⁷; and

- (ii) OneCity Health Delivery System Reform Incentive Payment (“DSRIP”) Program Performing System Partners.

C. Agent

For purposes of this OP, the term “Agent” shall mean any individual or entity that has entered into an agency relationship with the System. Depending on their System functions and duties, agents may fall under the definition of the terms Workforce Members or Business Partners.

7. ATTACHMENTS

A. Significance

The attachments to this OP, which are discussed in greater detail in subdivision “B” of this section below, are annexed hereto for, in pertinent part, one or more of the following key reasons:

- (i) To assist Covered Persons to better understand their compliance obligations under this OP by providing a summary of the key points of the OP and documents referenced in the OP;
- (ii) To ensure that certain documents that are referenced in the OP are easily available in their entirety for Covered Persons to review; and
- (iii) To further inform and educate Covered Persons on the fine nuances and various requirements the System must meet to maintain an effective compliance program.

Covered Persons should review and familiarize themselves with these Attachments upon reviewing the body of this OP. The ten (10) attachments to this OP are, in numerical order, set forth in subdivision “B” of this section.

B. Description of Attachments

- (i) Attachment I – *NYC Health + Hospitals Corporate Compliance Ethics Program – Summary of Workforce Member, Business Partner, and Agent Responsibilities.*

³⁷ See *id.*

This document provides a one page (back and front) summary of overview of the responsibilities of Covered Persons under the System’s Corporate Compliance and Ethics Program.

- (ii) *Attachment II - An Overview of Operating Procedure 50-1 – NYC Health + Hospitals Corporate Compliance and Ethics Program: A Roadmap to Assist Workforce Members, Business Partners, and Agents to understand their Responsibilities and Obligations under OP 50-1.*

This document, which is written in PowerPoint Presentation form, is designed to provide Covered Persons with a summary of the key provisions of OP 50-1, including, but not limited to, some of the pertinent requirements and responsibilities Covered Persons are subject to under OP 50-1.

- (iii) *Attachment III – Operating Procedure 50-1 – Corporate Compliance and Ethics Program, Understanding the Terms Fraud, Waste, and Abuse.*

This document further defines the terms *fraud*, *waste*, and *abuse* and provides examples for each of these terms.

- (iv) *Attachment IV – Summary of Elements for an Effective Compliance and Ethics Program.*

This document, which is in chart form, describes some of the additional compliance program elements that the System must comply with in order to satisfy Federal and/or State laws that govern specialty compliance programs such as, for example, accountable care organizations, nursing homes, DSRIP Program, FQHCs, and health plans.

- (v) *Attachment V-a- NYC Health + Hospitals Principles of Professional Conduct (“POPC”).*

The POPC is a guide that sets forth NYC Health + Hospitals’ compliance expectations and commitment to comply with all applicable Federal and State laws (*see* subdivision “A” of § 17 [**Standards of Conduct**], *infra*, for more information about the POPC).

- (vi) *Attachment V-b- NYC Health + Hospitals Principles of Professional Conduct Frequently Ask Questions (“FAQs”) (“POPC FAQs”).*

This document provides answers to questions that Covered Persons may have about the POPC.

- (vii) Attachment VI – *New York City Conflicts of Interest Board - New York Conflicts of Interest Law, Covering New York City Public Servants* (Plain Language Version).

This document is a one page (double-sided) guide created by the New York City Conflicts of Interest Board (“COIB”) that provides an overview of the New York City Conflict of Interest Board Rules.

- (viii) Attachment VII - *NYC Health + Hospitals Code of Ethics Summary of Key Provisions*.

This document provides a “plain language” short-form version of the System’s Code of Ethics.

- (ix) Attachment VIII – *NYC Health + Hospitals Corporate Compliance and Ethics Program Outline of Disciplinary Policy*

This document summarizes the NYC Health + Hospitals Disciplinary Policy as found below in § 23 [**Disciplinary Policy**] of this OP.

- (x) Attachment IX - *Overview of New York Labor Law §§ 740 and 741 and other Whistleblower Protection Laws*.

This document outlines the requirements under Labor Law §§ 740 and 741 and provides a summary comparison table of the two laws. Additionally, this document provides a summary review of other whistleblower protection laws.

8. PROGRAM REQUIREMENTS

The System must at all times operate and maintain an effective compliance program.³⁸ For purposes of this OP, the term “effective compliance program” shall mean a Program that, at a minimum:

- A. Consists of the following elements:³⁹

³⁸ See 18 NYCRR § 521.1 (requiring an effective compliance program in order “[t]o be eligible to receive medical assistance payments for care, services, or supplies, or to be eligible to submit claims for care, services, or supplies for or on behalf of another person . . .”). See also, generally, 63 Fed. Reg. at 8987-88, § [I][A] (1998)(providing, in pertinent part, that implementing an effective compliance program benefits a hospital by helping it to fulfill “its legal duty to ensure that it is not submitting false or inaccurate claims to [the] government and private payors . . .”); 70 Fed. Reg. 4858, 4859, § [I][A](2005)(same); FSG Guidelines § 8B2.1[Commentary: Background] (outlining, in brief, that the establishment of an effective compliance program is “intended to achieve reasonable prevention and detection of criminal conduct . . .”).

³⁹ While the elements of an effective compliance program listed in subdivision “A” of § 8, *supra*, are based on State law and regulations, the OIG Compliance Program Guidance for Hospitals sets forth seven similar key compliance elements that it recommends all hospitals, “regardless of [their] size, location or corporate structure, to establish an

- (i) The promulgation of written policies and procedures that outline, among other things:⁴⁰
 - (a) The expectations of the Program as provided in a code of conduct;
 - (b) Implementation of the Program;
 - (c) Guidance to Covered Persons on dealing with potential compliance concerns (“Compliance Concerns”); and
 - (d) How reported Compliance Concerns are investigated and resolved.
- (ii) The appointment of a CCO responsible for the Program’s day-to-day operation;⁴¹
- (iii) The provision of training and education for all Covered Persons;⁴²
- (iv) The establishment of communication lines to the responsible compliance person that are accessible to all Covered Persons to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith Compliance Reporting;⁴³
- (v) The establishment of disciplinary policies to encourage good faith participation in the compliance program, including policies that articulate expectations for Compliance Reporting, resolving compliance issues, and outlining sanctions for failing to report suspected problems, participating in non-compliant behavior or encouraging, directing, facilitating or permitting (either actively or passively) non-compliant behavior;⁴⁴
- (vi) The creation of a process to routinely identify compliance risk areas;⁴⁵
- (vii) A system to address Compliance Concerns that come to the attention of the OCC;⁴⁶
- (viii) The establishment of a whistleblower protection policy;⁴⁷

effective compliance program.” 63 Fed. Reg. 8988, 8989, § [I][B] (1998). Likewise, the OIG Compliance Program Guidance for Nursing Homes and Home Health Agencies reiterate the importance of these seven similar key elements in establishing an effective compliance program.

⁴⁰ 18 NYCRR § 521.3[c][1].

⁴¹ *Id.* at § 521.3[c][2].

⁴² *Id.* at § 521.3[c][3].

⁴³ *Id.* at § 521.3[c][4].

⁴⁴ *Id.* at § 521.3[c][5].

⁴⁵ *Id.* at § 521.3[c][6].

⁴⁶ *Id.* at § 521.3[c][7].

⁴⁷ *Id.* at § 521.3[c][8].

- B. Applies to:
- (i) Billing and claims submission;⁴⁸
 - (ii) Payments and claims reimbursement;⁴⁹
 - (iii) Mandatory reporting, including overpayments;⁵⁰
 - (iv) Medical necessity and quality of care;⁵¹
 - (v) Credentialing;⁵²
 - (vi) Corporate governance;⁵³ and
 - (vii) Any other risk area that is identified, or should with due diligence be identified, by the System.⁵⁴
- C. Satisfies all applicable Federal and State laws and other System legal obligations that govern the System’s compliance program responsibilities and oversight activities including, without limitation, compliance requirements applicable to:
- (i) Nursing homes and long-term care acute facilities;
 - (ii) Accountable care organizations;
 - (iii) FQHCs;
 - (iv) The New York State Department of Health (“SDOH”) DSRIP Program;⁵⁵
 - (v) World Trade Center Health Program;
 - (vi) Medicare Advantage Organizations and their first tier, downstream, and related entities, as applicable; and
 - (vii) Health plans.

Note: Attachment “IV” - *Summary of Elements for an Effective Compliance and Ethics Program* - provides a chart that outlines some of the various compliance

⁴⁸ See *Id.* at § 521.3[a][1].

⁴⁹ See *Id.* at § 521.3[a][2].

⁵⁰ See *Id.* at § 521.3[a][5].

⁵¹ See *Id.* at § 521.3[a][3].

⁵² See *Id.* at § 521.3[a][6].

⁵³ See *Id.* at § 521.3[a][4].

⁵⁴ See *Id.* at § 521.3[a][7].

⁵⁵ DSRIP Compliance Guidance 2015-01-Revised Special Considerations for Performing Provider System (“PPS”) leads’ compliance Programs (September 1, 2015).

program requirements under different applicable State and Federal Laws, as well as agency guidance.

9. COMPLIANCE STAFFING AND BUDGET

- A. The System’s President and Chief Executive Officer (the “President”) shall appoint the System’s CCO. The CCO shall be responsible for:
- (i) Directing compliance activities across the System;
 - (ii) Operating the OCC; and
 - (iii) Carrying out the reporting requirements, responsibilities, and procedures listed hereunder in §§ 10 [**Reporting**], 13 [**Responsibilities of the CCO and Other Compliance Personnel**], and 14 [**Procedures of the CCO and Other Compliance Personnel**], *infra*.
- B. The CCO must be an employee of NYC Health + Hospitals.⁵⁶ For purposes of this subdivision, an employee is “anyone who qualifies as an employee for NYS or federal employment tax purposes.”⁵⁷ The CCO shall not be an independent contractor, volunteer, consultant, leased employee, person supplied by a Professional Employee Organization or a Management Services Organization or similar individuals, as these individuals are not consider employees.⁵⁸
- C. The President has ultimate authority over budgeting, staffing, and personnel decisions related to the OCC. The CCO will annually submit a corporate-wide compliance staffing plan to the President and present proposed alterations to the approved staffing plan to the President.
- D. Unless otherwise prohibited by applicable law, all dedicated compliance staff shall be paid under the CCO's cost center.

10. REPORTING

- A. The CCO shall report directly to the President, in the President’s capacity and role as a member of the NYC Health + Hospitals Board of Directors (hereinafter also referred to as the “Board” or the “Governing Body”). The CCO shall also have supplemental (“dotted line”) direct access to the Audit Committee of the Board (the “Audit Committee”). Similarly, the Audit Committee will have direct access to the CCO.

⁵⁶ 18 NYCRR § 521.3 [c][2].

⁵⁷ See New York State Office of the Medicaid Inspector General Compliance Program Review Guidance, *New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 2 at § 2.1 (1), p.9.

⁵⁸ See *id.*

- B. The CCO shall report on significant Compliance activity in quarterly meetings with:
 - (i) The Chairperson of the Audit Committee; the Chairperson of the NYC Health + Hospitals Board of Directors; and the President; and
 - (ii) The Chairperson of the Compliance Committee of NYC Health + Hospitals/Gotham Health Board of Directors.
- C. The CCO, at his or her discretion, may report directly to the Chairperson of the Audit Committee on selected matters.
- D. The CCO shall report periodically to the Governing Body of the HHC ACO, Inc., as well as other System subsidiaries as appropriate.
- E. Where appropriate, the CCO shall make external reports to the appropriate Federal, State, and local regulatory bodies and/or law enforcement agencies.
- F. All Compliance Officers charged with providing compliance oversight activities at the various System acute care, long-term care, and ambulatory care sites shall report directly to the CCO (or his/her designee).
- G. Program Compliance Officers (“PCOs”), who are Compliance Officers charged with providing compliance oversight activities at the various System units and entities including, for example, the World Trade Center Health Program, At Home, Correctional Health Services, OneCity Health/DSRIP, and HHC ACO, Inc., shall, unless otherwise prohibited by applicable law, report directly to the CCO (or his/her designee).
- H. The Corporate Privacy and Security Officer (“CPSO”), who is charged with the development and implementation of policies and procedures with respect to protected health information, private information, employee health and other types of confidential employee identifying information, and other types of confidential System information that are reasonably designed to comply with the standards, implementation specifications or other requirements found under Federal and State privacy and data security laws including, without limitation, patient and employee confidentiality laws, shall report directly to the CCO (or his/her designee).⁵⁹

⁵⁹ See 45 CFR §§164.530 [a][1][i], [i][1] and 164.308 [a][2]; Pursuant to 45 CFR §§ 164.308 [a][2] and 164.530 [a][1][i] and System OPs 250-07 and 240-26, the CPSO is responsible for, among other functions and duties: (i) the development and implementation of policies and procedures consistent with Federal and State privacy and confidentiality laws and the System’s policies; (ii) receiving complaints and investigating possible privacy and security related incidents; and (iii) unless otherwise provided by applicable law, providing compliance oversight of the activities of the facility, unit, and entity compliance officers as such activities relate to privacy and data security.

- I. The System’s Corporate Records Management Officer (“CRMO”), who is the individual charged with developing, coordinating, and overseeing the System’s Corporate Record Management Program, shall report directly to the CCO.⁶⁰
- J. All System facility, unit, and entity Record Management Officers (“FRMOs”), who are responsible for assisting the CRMO with System-wide record management efforts, shall have supplemental (dotted line) reporting responsibilities to the CRMO.⁶¹
- K. Compliance Liaisons, who pursuant to CMS regulations governing long-term care facilities provide assistance to the CCO and the Compliance Officers assigned to the System’s various long-term care facilities with their duties, functions, and other activities, shall have supplemental (“dotted line”) reporting responsibilities to the CCO with regard to these activities.⁶² “Compliance [L]iaisons are not compliance officers.”⁶³ However, Compliance Liaisons shall be considered compliance personnel⁶⁴ for purposes of subdivisions A, I, and J of § 14 [**Procedures of the CCO and Other Compliance Personnel**], *infra*. Further, Compliance Liaisons shall be subject to the policies and procedures promulgated by the CCO as they relate to their Compliance Liaison functions, and shall be directly answerable to the CCO with regard to fulfilling these functions. Compliance Liaisons shall immediately report any knowledge of a potential, actual or suspected commission of a Prohibited Act (*see* subdivision “D” of § 23 [**Disciplinary Policy**]) to the compliance officer charged with oversight of the facility that the Compliance Liaison is assigned to or the CCO (or his/her designee). The CCO has the discretion and authority to remove a Compliance Liaison from their compliance activities where the CCO determines that such action is necessary to preserve the integrity of the Program or is otherwise in the best interest of the Program and the System. Any such removal shall be implemented in a manner that adheres to applicable law and the System’s Human Resources and Labor Relation policies and procedures.

The CCO, in consultation with the Senior Vice President of Long-term Care and the Chief Executive Officer (“CEO”) of each System long-term care facility, shall determine the qualifications, duties, and responsibilities of the Compliance Liaisons as they relate to their compliance functions and activities.⁶⁵ The CEO of each long-term care facility shall, in consultation with the CCO, appoint the Compliance Liaison for the facility under the CEO’s oversight.

⁶⁰ See 8 NYCRR § 185.1[a]; *see also* subdivision “d” of § XII of NYC Health + Hospitals OP 120-19 (*Corporate Record Management Program and Guidelines for Corporate Record Retention and Disposal*). Note that, the System’s Record Management program shall be operated in accordance with OP 120-19.

⁶¹ See OP 120-19.

⁶² See 42 CFR § 483.85 [d][3]; *see also* 80 Fed. Reg. 42168, 42220 (2015); 81 Fed. Reg. 68668, 68815-16 (2016).

⁶³ 81 Fed. Reg. 68668, 68815-16 (2016).

⁶⁴ Note that the terms “compliance personnel” and “compliance officer personnel” are used interchangeably throughout this OP.

⁶⁵ See, generally, 81 Fed. Reg. 68668, 68816 (2016).

11. ESTABLISHMENT OF COMPLIANCE COMMITTEES

The CCO shall ensure the establishment and operation of the following compliance committees:

A. The Executive Compliance Workgroup

- (i) The Executive Compliance Workgroup (“ECW”) is a standing committee that will meet as needed, but in no event less than three times in a calendar year, to:
 - (a) Discuss compliance issues, initiatives, and concerns (collectively hereinafter referred to as “issues”); and
 - (b) Provide advice and guidance to the CCO.
- (ii) The ECW shall be chaired by the CCO and the Executive Vice President for Operations (or Corporate Chief Operating Officer). The standing ECW members include the System’s General Counsel (or his/her designee), Corporate Chief Medical Officer, Chief Financial Officer, Senior Assistant Vice President for Revenue Management, Chief Information Officer, and Chief People Officer. In the absence of an Executive Vice President, the President shall, at his/her sole discretion, either co-chair the ECW with the CCO, or appoint the Senior Vice President or Vice President of Operations to serve as co-chair of the same.
- (iii) In addition to the standing ECW members, the ECW shall consist of the following rotating members, each of whom shall be selected by the President for a term of one year:
 - (a) The Senior Vice President for Hospitals and Ambulatory Care or the Senior Vice President for Post-Acute Care;
 - (b) An acute care facility Chief Executive Officer; and
 - (c) A long-term care facility Chief Executive Officer.

B. The ECW Subcommittee on Compliance and Quality

- (i) The ECW Subcommittee on Compliance and Quality (“ECW-CQ”), which is a standing subcommittee of the ECW, will meet as needed, but in no event less than once a year, to discuss compliance issues specifically related to the following:
 - (a) Medical necessity;
 - (b) Quality of care;

- (c) Credentialing; and
 - (d) Medical record documentation.
- (ii) The ECW-CQ shall be chaired by the System’s CCO and the Corporate Chief Medical Officer, and includes the System’s General Counsel (or his/her designee), Vice President for Quality, Deputy Corporate Chief Medical Officer; Corporate Chief Nursing Officer; Corporate Risk Management Officer; the Senior Director of Quality; Assistant Vice President of Patient Relations; and the System’s Joint Commission principal liaison for System-wide accreditation activities.

C. The OneCity Health/DSRIP Compliance Committee

- (i) The OneCity Health/DSRIP Compliance Committee, which is a standing subcommittee of the ECW, shall meet as needed, but in no event less once a calendar year, to discuss DSRIP-related compliance issues.
- (ii) The OneCity Health/DSRIP Compliance Committee is chaired by the CCO and the Vice President of OneCity Health, and includes the Chairperson of OneCity Health, the System’s General Counsel (or his/her designee); Corporate Chief Nursing Officer; Chief Financial Officer (or his/her designee); and the OneCity Health/DSRIP Chief Financial Officer.

D. The Correctional Health Services Compliance Committee

- (i) The Correctional Health Services (“CHS”) Compliance Committee, which is a standing sub-committee of the ECW, shall meet as needed, but in no event less than one time in a calendar year.
- (ii) The CHS Compliance Committee will be chaired by the CCO and the Senior Vice President for Correctional Health Services, and shall include the following four leaders of CHS:
 - (a) The Chief Medical Officer;
 - (b) The Chief Operating Officer;
 - (c) The Assistant Vice President for Policy and Planning; and
 - (d) The Senior Director for Finance.

The CHS Compliance Committee shall also include the System’s CPSO and CRMO, and the System’s General Counsel (or his/her designee).

E. The ECW Subcommittee on Compliance and Long-term Care

- (i) The ECW Subcommittee on Compliance and Long-term Care (“ECW-LTC”), which is a standing subcommittee of the ECW, shall meet as needed, but in no event less than one time in a calendar year, to discuss compliance issues related to the System’s long-term care facilities.
- (ii) The ECW-LTC shall be chaired by the CCO and the Senior Vice President for Long-term Care, and shall include the Chief Executive Officer of each System long-term care facilities, the System’s General Counsel (or his/her designee), the System’s Chief Information Officer, the System’s Chief Financial Officer (or his/her designee), the System’s Chief Medical Officer, the System’s Vice President for Quality, the System’s Vice President for Human Resources, and the System’s Corporate Risk Manager.
- (iii) In addition to the standing ECW-LTC members, the ECW-LTC shall consist of the following rotating members, each of whom shall be selected by the chairs of the ECW-LTC for a term of one year:
 - (a) A long-term care facility Medical Director; and
 - (b) A long-term care facility Risk Manager.

F. HHC ACO Inc. Compliance Committee

- (i) The HHC ACO Inc., Compliance Committee, which is a standing subcommittee of the ECW, shall meet as needed, but in no event less than one time in a calendar year.
- (ii) The HHC ACO, Inc., Compliance Committee is chaired by the CCO and the Senior Director of the HHC ACO, Inc., and shall include the Chief Executive Officer of the HHC ACO, Inc., the Medical Director of the HHC ACO Inc., the System’s Corporate Chief Medical Officer, the System’s General Counsel (or his/her designee), and the System’s Chief Information Officer (or his/her designee).

G. ECW’s Authority to Establish Compliance Subcommittees

In addition to the subcommittees outlined in subdivisions B-F of this section, *supra*, the chairs of the ECW shall, as they deem necessary in furtherance of the Program, or as otherwise directed by the President, establish other standing or special subcommittees (*e.g.*, committees concerning the World Trade Center Health Program, NYC Health + Hospitals, At Home, environmental compliance, human resources/labor, *etc.*) and appoint initial members thereto to address compliance concerns that require focused attention. The chairs of these subcommittees may

appoint additional members as they deem necessary in the furtherance of these subcommittees.

H. Special Ad-hoc Committees

The CCO, at his/her sole discretion, may establish and chair special ad-hoc compliance committees as he/she deems necessary in furtherance of the Program. For example, committees pertaining to training and education; internal investigations and discipline; and risk assessment and prioritization scoring.

I. Facility Compliance Committees

- (i) Each acute care facility, long-term care facility, and D&TC shall establish a Facility Compliance Committee (“FCC”), which will be chaired by the Compliance Officer within the OCC assigned to provide compliance oversight activities to that facility. Facilities may, upon the request of the facilities’ CEOs, and subject to the approval of the chairs of the ECW, form joint FCCs where compliance issues involving more than one System facility are discussed. For example, the executive leadership of the facilities that constitute NYC Health + Hospitals/Gotham Health may conclude for purposes of efficiency, efficacy, and compliance policy oversight and implementation that joint FCC meetings are in the best interest of their facilities with the primary goal of furthering Program objectives.
- (ii) FCCs shall include standing facility members appointed by the Facility CEO from the following departments, as applicable:
 - (a) Finance;
 - (b) Patient Accounts;
 - (c) Quality Assurance;
 - (d) Health Information Management;
 - (e) Human Resources;
 - (f) Internal controls;
 - (g) Medicine;
 - (h) Utilization Review;
 - (i) Risk Management;
 - (j) Environmental;

- (k) Information Technology;
 - (l) Nursing; and
 - (m) Other departments as needed.
- (iii) FCCs shall meet as needed but in no event less than three times in a calendar year.

12. RESPONSIBILITIES OF ALL COVERED PERSONS

- A. All Covered Persons are required to affirmatively participate in the Program, which includes, for example, the following:
- (i) Conducting themselves in a manner that is ethical, legal, and consistent with the System's culture of compliance as collectively described in § 2-a [**“Compliance” and “Ethics” Defined**], *supra*;
 - (ii) Compliance Reporting as described in subdivisions “A” and “B” of § 22 [**Mandatory Reporting and Compliance with Investigations**], *infra*;
 - (iii) Refraining from engaging in retaliatory conduct, as described in subdivisions “A”, “B”, and “C” of § 24 [**Retaliation Prohibited/Whistleblower Protection**], *infra*;
 - (iv) Cooperating with internal investigations as described in subdivision “C” of § 22 [**Mandatory Reporting and Compliance with Investigations**], *infra*;
 - (v) Adhering to the Standards of Conduct outlined in § 17 [**Standards of Conduct**];
 - (vi) Complying with this OP and applicable law as set forth in § 21 [**Mandatory Compliance**], *infra*;
 - (vii) Refraining from engaging in any of the Prohibited Acts outlined in subdivision “D” of § 23 [**Disciplinary Policy**], *infra*;
 - (viii) Protecting the confidentiality, privacy, and security of confidential (*e.g.*, patient protected health information; the personally identifiable information and/or private information of Covered Persons; and System business information that is proprietary, protected under a legal privilege or applicable law, or is otherwise not subject to public disclosure) and refraining from accessing, disclosing, transmitting, or otherwise using confidential System information in a manner that is inconsistent with applicable law or the System's internal information governance policies or contractual requirements (*e.g.*, business

associate, qualified service organization agreements, and other contractual provisions that govern the use of confidential information).

- B. To better understand their responsibilities, Covered Persons are hereby advised to, in addition to reading the body of this OP, review each of the attachments (*see* § 7 [Attachments], *supra*) annexed to this OP.

13. RESPONSIBILITIES OF THE CCO AND OTHER COMPLIANCE PERSONNEL

The CCO shall have primary responsibility for the following:

A. Providing Oversight to the Program

- (i) Developing, operating, overseeing, and monitoring the implementation of the Program;⁶⁶
- (ii) Serving as the focal point for the System's compliance activities;⁶⁷ and
- (iii) Assisting the Governing Body, President, and members of the ECW and other System compliance committees in establishing methods to improve the System's efficiency and quality of services, and reduce the System's vulnerability to fraud, waste, and abuse.

B. Periodically Revising the Program

- (i) Periodically revising the Program, as necessary, in response to:⁶⁸
 - (a) the System's needs, mission, and goals; and
 - (b) applicable Federal and State laws and payor policies and procedures;

C. Performing Independent Investigations

Consistent with subdivision "J" of § 14 [Procedures of the CCO and Other Compliance Personnel], *infra*, independently investigating compliance concerns including the flexibility to design and coordinate independent investigations and resulting corrective action and mitigation plans;⁶⁹

⁶⁶ See U.S. Department of Health and Human Services Office of Inspector General, *Publication of the OIG Compliance Program Guidance for Hospitals*, § [II][B][1], 63 Fed. Reg. 8987, 8993 [1998].

⁶⁷ See U.S. Department of Health and Human Services Office of Inspector General, *Publication of the OIG Compliance Program Guidance for Hospitals*, § [II][B][1], 63 Fed. Reg. 8987, 8993 [1998].

⁶⁸ See U.S. Department of Health and Human Services Office of Inspector General, *Publication of the OIG Compliance Program Guidance for Hospitals*, § [II][B][1], 63 Fed. Reg. 8987, 8993 [1998].

⁶⁹ See U.S. Department of Health and Human Services Office of Inspector General, *Publication of the OIG*

D. Developing Compliance Training Programs

- (i) Consistent with § 18 [**Workforce Training and Education**], *infra*, developing, disseminating, and monitoring regular and consistent compliance training and education to strengthen the ability of Compliance personnel to carry out Program functions. Such training for FCOs and PCOs should be consistent with the best practices for compliance training for comparable entities and will include, where appropriate, web-based or on-line training and other formal training leading to certification of compliance officers.
- (ii) Consistent with § 18 [**Workforce Training and Education**], *infra*, overseeing, implementing, and measuring regular and consistent training for Covered Persons with the goal that:
 - (a) Covered Persons are aware of the Program’s requirements; and
 - (b) Covered Persons have the requisite awareness, knowledge, and respect for pertinent standards of ethical and lawful conduct and that they meet these standards in the performance of their System duties and functions; and
- (iii) Issuing advisories to facilities and/or departments to raise awareness of known or potential compliance vulnerabilities and to alert them to changes in relevant:
 - (a) Federal and State laws; and
 - (b) Federal healthcare program and private payor requirements.

E. Performing System-wide Risk Assessment Activities

- (i) Performing System-wide Risk Identification, Assessment, and Prioritization (hereinafter collectively “Risk Assessment”) activities and presenting findings and the resulting Corporate Compliance Work Plan (*see* ¶ (ii) of this subdivision, *infra*) to the President and Audit Committee of the NYC Health + Hospitals Board of Directors for risk appetite determinations.
- (ii) Subject to the review and approval of the President, developing and implementing, on an annual basis, a Corporate Compliance Work Plan (the

Compliance Program Guidance for Hospitals, § [II][B][1], 63 Fed. Reg. 8987, 8994 [1998].

“Work Plan”). The Work Plan shall be derived from, in pertinent part, a review of:

- (a) Facility, program and corporate compliance issues;
 - (b) Annual work plans and corresponding periodic updates, relevant audit protocols, and enforcement actions from external enforcement bodies including, but not limited to, OIG and OMIG; and
 - (c) The results of the System-wide Risk Assessment activities described in ¶ (i) of this subdivision, *supra*.
- (iii) Assigning Work Plan items for review to responsible individuals with a defined period for completion and the development of a corrective action plan (where necessary). The Work Plan shall include and incorporate, without limitation, the review and approval of facility and program Work Plans, which are ultimately subject to the final approval of the President. The Work Plan shall be disseminated to the FCOs and PCOs.
- (iv) Initiating and conducting, with the approval of the President, targeted System-wide compliance review(s) or audit(s).

F. Monitoring Compliance Committee Participation

Monitoring of the attendance at meetings of the FCC and, as assigned, other compliance committees to ensure that activities that stem from these committees further the Program and the Work Plan.

G. Maintaining a Confidential Process for the Reporting of Compliance Issues

Overseeing a confidential process, including a toll-free confidential compliance helpline, to receive reports of compliance issues, and ensuring the use of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.⁷⁰

H. Reporting Compliance Issues and Concerns to the Governing Body

In addition to the reporting responsibilities outlined in subdivisions “A-E” of § 10 [Reporting], *supra*, requesting, as necessary, the Chairperson of the Board of

⁷⁰ See U.S. Department of Health and Human Services Office of Inspector, *General Publication of the OIG Compliance Program Guidance for Hospitals*, § [II][D][1] & [2], 63 Fed. Reg. 8987, 8995 [1998].

Directors to call a meeting of the Board of Directors to consider any issues or concerns requiring their attention.

I. Developing Compliance Policies and Procedures

Developing policies and procedures that:

- (i) Provide Covered Persons with guidance on compliance issues and concerns⁷¹; and
- (ii) Facilitate compliance with the Program by Covered Persons.

J. Encouraging Covered Person Participation in the Program

Creating incentives to promote Covered Person compliance with the Program and corresponding plans and activities to sustain such compliance.

K. Measuring the Effectiveness of the Program

Developing metrics and other measurements to assess the execution and effectiveness of the Program, the implementation of remedial measures and mitigation efforts, and the development of reports and dashboards to assist the Board in its evaluation of the program.⁷²

L. Developing Compliance Plans for Specialty System Programs

Developing compliance plans for specialty programs such as OneCity Health/DSRIP, HHC ACO, Inc., and System nursing homes and long-term acute care facilities.⁷³

M. Establishing and Enforcing the System's Whistleblower Protection Policies

Consistent with § 24 [**Retaliation Prohibited/Whistleblower Protection**], *infra*, fostering programs and activities that promote Compliance Reporting by Covered Persons without fear of retaliation.⁷⁴

⁷¹ See OIG HHS Association of Healthcare Internal Auditors, American Health Lawyers Association and Health Care Compliance Association, Practical Guidance for Health Care Governing Board on Compliance Oversight, Roles and Relationships [The compliance function], p. 6.

⁷² See *id.*

⁷³ Where appropriate, such specialty program compliance plans may be incorporated as part of the NYC Health + Hospitals Compliance Plan.

⁷⁴ See U.S. Department of Health and Human Services Office of Inspector General, *Publication of the OIG Compliance Program Guidance for Hospitals*, § [II][B][I], 63 Fed. Reg. 8987, 8994 [1998].

N. Supervising the Activities of Compliance Personnel

- (i) Consistent with applicable corporate policies, the CCO shall assure the supervision - - either directly or through assigned senior compliance personnel or other supervising compliance officers - - of FCOs. Additionally, as stated in subdivisions “J” and “K” of § 10 [**Reporting**], *supra*, the CCO shall have supplemental-dotted line oversight of certain duties and functions of the FRMOs and Compliance Liaisons, respectively.
- (ii) Where appropriate and as needed in the best interest of the Program, reassigning FCOs and PCOs to perform compliance functions at different facilities and programs.
- (iii) Under the oversight and direction of the CCO (or his/her designee), FCOs and PCOs will have primary responsibility for, among other things, the following:
 - (a) Reporting facility and program compliance activities to the CCO;
 - (b) Conducting an annual Risk Assessment at their facility or program and, with the CCO, selecting items resulting from the Risk Assessment for development of the Corporate Compliance Work Plan;
 - (c) Reviewing the annual (including any supplements thereto) Work Plans, fraud alerts, compliance program guidance, and publicly available enforcement or settlement actions issued by OIG, OMIG, Centers for Medicare and Medicaid Services (“CMS”), Office for Civil Rights (“OCR”), and other regulatory and enforcement bodies to identify possible areas of System risk;
 - (d) Assigning Work Plan items for review to responsible individuals at the System facilities, units, and entities under the oversight of the FCO and PCO. Submitting to the CCO quarterly reports reflecting progress made in addressing items on the Work Plan;
 - (e) Scheduling each compliance committee meeting that corresponds to their facility and/or program that they are charged with compliance oversight of. Developing a corresponding meeting agenda, maintaining minutes and reports documenting facility and program compliance activity since the last compliance committee meeting, and implementing corrective action plans, where appropriate. All minutes and reports shall be supplied to the CCO. Absent extraordinary circumstances, attendance by compliance committee members at these meetings is mandatory and attendance sheets shall

- be provided to the CCO for his/her review and monitoring. The CCO shall report the same to the President;
- (f) As requested by the CCO, providing periodic presentations before the ECW regarding ongoing System-wide compliance activities;
 - (g) Reviewing, responding to, and addressing Compliance HelpLine Reports, as required, when referred from the CCO;
 - (h) Ensuring completion of compliance training for all compliance committee members and, as assigned, other compliance committee members, group 11 employees, physicians, healthcare professionals, and other designated Covered Persons (as determined and required by the CCO) and reporting to the CCO on a regular basis the status of training activities;
 - (i) Reviewing internal controls within the facilities, units, programs, and entities to which they are assigned to evaluate their efficacy in detecting and preventing significant instances or patterns of unethical, illegal, or improper conduct, and recommending to the CCO revisions of procedures as necessary to fulfill the obligations of the Program or as required by law; and
 - (j) Assisting the CCO with Program implementation and other compliance oversight activities as designated or otherwise assigned by the CCO or other supervising compliance officer.

14. PROCEDURES OF THE CCO AND OTHER COMPLIANCE PERSONNEL

A. Adherence to the Code of Ethical Compliance Conduct

In carrying out compliance duties and functions, the CCO and all other compliance officer are responsible for “embrac[ing] the spirit and the letter of the law governing”⁷⁵ the System’s conduct, activities, and operations. Additionally, all compliance personnel shall:

- (i) “[E]xemplify the highest ethical standards in”⁷⁶ carrying out their responsibilities “in order to contribute to the public good”⁷⁷; and
- (ii) Refrain from aiding, abetting, or participating in misconduct.⁷⁸

⁷⁵ HCCA Code of Ethics of Health Care Compliance Professionals, Principle 1 (emphasis added), available at: <http://www.hcca-info.org/Portals/0/PDFs/Resources/HCCACodeOfEthics.pdf>.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* at R1.1.

All compliance personnel, as led by the CCO, “shall take such steps as necessary to prevent misconduct” from occurring within and by the System.⁷⁹

B. Delegation of Duties

The CCO may delegate to appropriate employees, departments or compliance workgroups or committees (such as, for example, Internal Audits, Inspector General, Office of Legal Affairs, Human Resources/Talent Acquisition, or a member of the ECW or a subcommittee thereof) the responsibility to conduct reviews of issues of concern if the CCO deems such reviews are necessary to fulfill the mission of the Program.

C. The Retaining of Outside Consultants

The CCO may request approval from the President to 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 in accordance with System policies and procedures.⁸⁰

D. Revision of System Procedures

The CCO may recommend to the President revision of procedures as are necessary to fulfill the CCO's obligations under this Policy or, as required by Federal or State law.

E. Review of Matters by Other Departments

The CCO shall determine if it is necessary for responsible employees or departments to conduct reviews of issues of concern including, for example, Work Plan items. Such employees or departments will be provided with guidelines of the scope of issues to be reviewed and a timeframe for completion. At each corresponding compliance committee meeting, a report will be entered into the minutes reflecting the status of each assigned Work Plan or other review item, the anticipated completion date of the review(s), and, where appropriate, a corrective action plan and schedule for subsequent re-audit to ensure that the issue does not recur, as well as any written summary of issues by the responsible employee/department on each item.

⁷⁹ *Id.* at R1.2.

⁸⁰ See OIG, Publication of the OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8997 (1998), § [II][G][1]; see also, generally, OIG Supplemental Compliance Program Guidance for Hospitals, Fed. Reg. 4858, 4875 [2005], § [III][B][1](highlighting that one factor that may be considered when evaluating if a compliance program is meeting its objective of ensuring that a hospital complies with applicable Federal healthcare program requirements is whether “the compliance officer [has] independent authority to retain outside counsel.”).

F. The Establishment of Compliance Subcommittees

The CCO shall direct compliance personnel to establish subcommittees of the FCC and other compliance committees, as necessary, to review and investigate possible compliance violations. FCOs and PCOs will report to the CCO allegations of violations of policy, procedure, or applicable law including, for example, violations related to any of the System’s compliance obligations listed in paragraphs (i-vi) of subdivision “A” of § 4 [**Purpose**], *supra*. Similarly, the FCO will report instances of non-compliance with applicable legal and regulatory requirements related to coding, billing, and financial transactions. If the results of a compliance review demonstrate that a violation has occurred, the FCO or PCO may recommend to the CCO appropriate corrective action and/or notification to the appropriate regulatory/government entity.

G. Review of Internal Controls

The CCO shall, as necessary, review internal controls to evaluate their efficacy in detecting and preventing significant instances or patterns of unethical, illegal or improper conduct, and will recommend to the President revisions of System-wide procedures and the strengthening of internal controls as are necessary to fulfill the CCO’s obligations under this OP or, as required, by Federal or State law.

H. Cooperation by Covered Persons with Compliance Reviews

The CCO shall ensure that, during the course of a review conducted by or under the auspices of the CCO or other compliance personnel, all Covered Persons interviewed shall be advised that every Covered Person has an affirmative obligation to cooperate with a review conducted by the CCO (or his/her designee) or by his/her delegated representatives. Additionally, the CCO shall further ensure that all Covered Persons interviewed during a compliance review are advised that:

- (i) As set forth in § 24 [**Retaliation Prohibited/Whistleblower Protection**], *infra*, the System strictly prohibits Retaliation against any Covered Person who reports, in good faith, the actual, potential or suspected commission of a Prohibited Act;⁸¹ and
- (ii) The confidentiality of the Covered Person’s report will be maintained to the extent required by law and in accordance with the OCC’s internal policies and procedures set forth below in ¶ (vii) of subdivision “J” of this section.

⁸¹ See HCCA Code of Ethics R2.5 (stating that “[health care compliance personnel] shall not aid or abet retaliation against any employee who reports actual, potential, or suspected misconduct, and they shall strive to implement procedures that ensure the protection from retaliation of any employee who reports actual, potential, or suspected misconduct.”).

I. Avoidance of the Appearance of Impropriety

(i) *Improprieties Must Be Avoided*

All compliance personnel shall exercise any and all measures necessary to avoid improprieties, as well as the appearance of improprieties, in carrying out their compliance functions, duties, and obligations. All compliance personnel must “avoid any actual, potential or perceived conflicts of interest” and report the same to the CCO when such conflicts are present or may potentially occur.⁸²

(ii) *Conflicts of Interests Defined*

For purposes of this subdivision only, conflicts of interest include, for example, any business or financial interest, or professional, family or personal relationship, “that could be substantial enough to influence [the] judgment” of compliance personnel in connection with the performance of their compliance responsibilities, functions, duties, or obligations.⁸³

(iii) *Loyalty to the System and Public is Paramount*

Compliance personnel shall refrain from permitting loyalties developed with Covered Persons “with whom they have developed a professional or personal relationship to interfere with or supersede [their] duty of loyalty to the [System] and/or [their] superior responsibility of upholding [applicable Federal and State] law”, the POPC, and the requirements of the Program.⁸⁴

(iv) *Managing Conflicts*

In situations where a conflict exists because a compliance matter involves the actual or potential commission of a Prohibited Act (as defined in subdivision D of § 23 [**Disciplinary Policy**], *infra*) that concerns the direct or indirect actions of a compliance workforce member, the affected compliance workforce member shall refrain from responding to, investigating or otherwise handling such a matter, and shall immediately report the same to the CCO.⁸⁵ The CCO shall take appropriate action to remove, mitigate or otherwise manage such conflicts where possible. Where a conflict exists within the OCC that cannot be appropriately managed, the CCO shall refer the matter to be investigated to the Office of Legal Affairs for handling and appropriate action. Notwithstanding anything stated to contrary hereinabove in subdivisions “B”, “E”, and “F” of § 14 [**Procedures of the CCO and Other Compliance Personnel**], the CCO and other compliance officer personnel shall not refer or otherwise assign the investigation into the suspected, actual or potential commission of a Prohibited Act to any Workforce Member

⁸² HCCA Code of Ethics at R2.7.

⁸³ *Id.* at R2.7 (commentary).

⁸⁴ HCCA Code of Ethics R2.7.

⁸⁵ *Id.* at R2.7 (commentary).

outside of the OCC who may be directly or indirectly involved with such Prohibited Act or who is otherwise conflicted. Further, prior to the assignment of compliance reviews, especially formal audits, the CCO and other compliance officer personnel shall appropriately assess whether the inherent need to maintain the independence and integrity of the OCC's compliance responsibilities will be adversely affected by such assignment and, if so, such assignment shall be avoided.

J. Investigatory Procedures

(i) *Compliance Report Tracking*

All compliance queries, reports, problems, issues or concerns raised or identified, complaints, and requests for guidance (collectively hereinafter "Reports") received or otherwise obtained by the OCC shall be assigned a compliance matter number and entered into the OCC's compliance tracking system.

(ii) *Permissive Investigations*

Except for the category of Reports listed in ¶ (iii) of this subdivision, *infra*, the CCO, exercising sound judgment on a case-by-case basis, shall have absolute investigatory discretion as to whether a Report concerning the potential, actual, suspected or imminent commission of a Prohibited Act warrants a responsive investigation.

(iii) *Mandatory Investigations*

The CCO shall, in each and every case, perform (or cause the performance thereof), with appropriate due diligence, a prompt, fair, impartial, and thorough investigation in response to:

- (a) A Report that involves the reasonable suspicion or other indication of the potential, imminent, suspected or actual substantial commission of a Prohibited Act;⁸⁶
- (b) A directive or request made by any of the following individuals to perform an investigation in response to a given Report:
 - The President or other member of the Governing Body;
 - The Chairperson of the Board of Directors or, as applicable, the Chairperson of a Compliance, Audit, Governance or Quality Assurance Committee of the Board of Directors of any wholly owned System subsidiary; or

⁸⁶ See OIG Publication of the OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8997 (1998), § [II][G][1]; see also 18 NYCRR § 521.3(c)(7).

- The Chairperson of the Gotham Health Board of Directors or, as applicable, the Chairperson of a Compliance, Audit, Governance or Quality Assurance Committee of the Gotham Health Board of Directors;
- (c) A Report that, pursuant to applicable Federal or State law, Federal healthcare program requirements or compliance operating procedures, requires a responsive investigation;
- (d) A Report that, although in itself may not warrant a responsive investigation, when examined in combination and totality with other similarly related Reports, facts, circumstances, and/or relevant past history, amounts to:
 - A pattern of ongoing misconduct or unethical behavior; or
 - A reasonable suspicion or other indication of a suspected, potential, imminent or actual substantial commission of Prohibited Act;
- (e) A Report regarding an allegation of Retaliation as defined in § 24 **[Retaliation Prohibited/Whistleblower Protection]**, *infra*;
- (f) A Report regarding an allegation of a HIPAA or other privacy violation;
- (g) A Report regarding allegations of the commission of a Prohibited Act that if true could result in an overpayment;
- (h) A Report regarding an allegation of the submission of a false or fraudulent claim;
- (i) A Report regarding an allegation of the commission of Stark Law and/or Anti-kickback Statute violations;
- (j) A Report regarding an allegation of the violation of patient rights, patient abuse or the compromise of patient safety;
- (k) A Report regarding an allegation of the commission of a Prohibited Act that if true could result in the imposition of civil monetary penalties;
- (l) A Report involving sexual or other Workforce Member harassment; or
- (m) A Report regarding an allegation of workplace safety including, without limitation, workplace violence.

(iv) *Conduct of Investigation*

- (a) Unless otherwise mandated by applicable Federal or State law, all investigations conducted under ¶¶ (ii) and (iii) of this subdivision, *supra*, shall be conducted with due diligence to determine whether there is credible evidence that a probable material commission of a Prohibited Act has occurred.⁸⁷
- (b) Investigations may include interviews, review of relevant documents and engaging outside counsel or auditors as appropriate.

(v) *Investigatory Records*

Compliance officer personnel shall maintain the following documentation and other records related to an investigation:⁸⁸

- (a) Documentation of the Prohibited Act that is the subject of the investigation at hand;
- (b) Documentation of the investigatory process employed to investigate whether the commission of a Prohibited Act had occurred;
- (c) Copies of the interview notes;
- (d) Copies of key documents reviewed;
- (e) The results of the investigation; and
- (f) Disciplinary Action (*see* § 23 **[Disciplinary Policy]**, *infra*) and/or corrective measures taken as a result of the investigation.

All documents and other records mentioned in the subparagraphs hereinabove must be maintained within the compliance tracking system to the extent reasonably possible. Where a hard copy of a record is maintained elsewhere, the specific location of such record must be documented in the compliance tracking system.

⁸⁷ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8997 (1998), § [II][G][1]; *see also, generally*, HCCA Code of Ethics R2.3 (providing that “[health care compliance personnel] shall investigate with appropriate due diligence all issues, information, reports and/or conduct that relate to actual or suspected misconduct, whether past, current or prospective.”).

⁸⁸ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8997 (1998), § [II][G][1].

(vi) *Maintenance of Witness and Document Logs*

Investigations conducted by compliance officer personnel that result in the interviewing of witnesses or the collection of documents shall be entered on separate and distinct confidential “Witness Logs” and “Document Logs”, respectively, and shall be unique for each compliance matter.⁸⁹ These documents must be maintained within the compliance tracking system.

(vii) *Confidentiality*

(a) Policy

The OCC shall establish and maintain methods for anonymous and confidential good faith reporting of potential compliance issues.⁹⁰

(b) Anonymity of Reporters

- Methods for Anonymous Reporting

The OCC shall establish and maintain at least one method of anonymous communication that is “truly anonymous so [Reporters] have assurance that there is no way the compliance function can discover who is reporting a matter.”⁹¹

- How to make an Anonymous Report?

Reporters who report compliance matters through the OCC toll free confidential helpline, at 1-866-HELP-HHC (1-866-435-7442), as outlined in subdivision “B” of § 22 **[Mandatory Reporting and Compliance with Investigations]**, *infra*, and elect not to provide their name or other identifying information when making a Report through this method, will remain anonymous.

(c) Confidential Communications Between Reporters and OCC

- In carrying out their investigatory functions, duties, and responsibilities, all compliance officer personnel and other

⁸⁹ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8997 (1998), § [II][G][1] (stating that “[r]ecords of [an] investigation should contain . . . a log of the witnesses interviewed and the documents reviewed.”).

⁹⁰ See 18 NYCRR § 521.3 (c)(4).

⁹¹ New York State Office of the Medicaid Inspector General Compliance Program Review Guidance, *New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 4 at 4.3 § at 4.3 § (1)(a)(i-ii), pgs. 18-19.

OCC staff shall make every reasonable effort, to the best of their ability, to preserve the confidentiality of Reporters.⁹²

- Although there is no requirement that all methods of communication to the OCC be confidential, the OCC must at least establish and maintain one method of confidential communication that is available to all Reporters.⁹³
- The confidentiality of Reporters shall be preserved where a Reporter specifically requests such confidentiality or has a reasonable expectation of the same.⁹⁴
- Reporters who report compliance matters as outlined in subdivision “B” of § 22 [**Mandatory Reporting and Compliance with Investigations**], *infra*, shall have a reasonable expectation of confidentiality. All of the methods of communication set forth in subdivision “B” of § 22 shall be deemed confidential methods of communication to the OCC. As such, all reports received through this method must be kept confidential, whether the Reporter requests the same or not.⁹⁵

(d) Limitations to Confidentiality

Notwithstanding anything stated hereinabove in subparagraphs (a) and (c) to the contrary, “under certain circumstances confidentiality must yield to other [System] values or concerns,”⁹⁶ including, for example:

- “[T]o stop an act which creates appreciable risk to [the] health and safety” of patients, Covered Persons or the public;⁹⁷

⁹² HCCA Code of Ethics for Health Care Compliance Professionals, Principle II, R2.5 (commentary).

⁹³ See New York State Office of the Medicaid Inspector General Compliance Program Review Guidance, *New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 4 at 4.3 § at 4.3 § (1)(b)(i-ii), p. 19.

⁹⁴ See New York State Office of the Medicaid Inspector General Compliance Program Review Guidance, *New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 4 at 4.3 § at 4.3 § (1)(b)(iii), p. 19 see also Code of Ethics for Health Care Compliance Professionals, Principle II, R2.5 (commentary).

⁹⁵ See New York State Office of the Medicaid Inspector General Compliance Program Review Guidance, *New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 4 at 4.3 § at 4.3 § (1)(b)(iii)(1), p. 19.

⁹⁶ See HCCA Code of Ethics for Health Care Compliance Professionals, Principle II, R2.6.

⁹⁷ See HCCA Code of Ethics for Health Care Compliance Professionals, Principle II, R2.6.

- “[T]o reveal a confidence when necessary to comply with a subpoena or other legal process”⁹⁸ provided that confidence or other information sought for disclosure is not covered under an applicable legal privilege;⁹⁹
- Where disclosure to law enforcement or a regulatory body is required by applicable Federal or State law and no applicable legal privileges apply; or
- Where the CCO determines that disclosure to law enforcement or a regulatory body is necessary as part of the System’s investigation into (or response to) a Report;¹⁰⁰

(viii) *Disclosure of Confidential Information Covered under Legally Recognizable Privileges held by the System*

- (a) Where, pursuant to subparagraph (d) of ¶ (vii) above, information to be disclosed (or requested to be disclosed) is covered under the attorney-client privilege, the CCO shall ensure that such disclosure is approved in writing by the General Counsel.
- (b) Where, pursuant to subparagraph (d) of ¶ (vii) above, information to be disclosed (or requested to be disclosed) is covered under other legally recognizable privileges - - not including the attorney-client privilege - - held by the System, the CCO shall, where appropriate, consult with the General Counsel (or his/her designee), before disclosing the same.
- (c) All confidential information released under subparagraphs (a) and (b) of this paragraph shall be subject to the minimum necessary in light of the reason for disclosure.
- (d) All confidential information that may be subject to a recognizable compliance program privilege shall be subject to the written approval of the CCO prior to disclosure.

⁹⁸ HCCA Code of Ethics for Health Care Compliance Professionals, Principle II, R2.6.

⁹⁹ See HCCA Code of Ethics for Health Care Compliance Professionals, Principle II, R2.6 (commentary).

¹⁰⁰ New York State Office of the Medicaid Inspector General Compliance Program Review Guidance, *New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 4 at 4.3 § (b)(iii)(2), p.19.

(ix) *Maintaining a Professional Investigation*

When carrying out their investigatory functions and duties, compliance officer personnel and other OCC staff shall proceed with the “utmost discretion, being careful to protect the reputations and identities of those being investigated” to the extent reasonably possible under a given set of circumstances.¹⁰¹ Nothing herein shall be construed to prevent the lawful disclosure of the identity of an individual or other party being investigated where:

- (a) Any of the circumstances outlined in subparagraph (d) of ¶ (vii) of this subdivision exists;
- (b) It is reasonably determined by the CCO that such disclosure will not have a chilling effect on Covered Person participation in the program or otherwise interfere with the policy purposes of the Program;
- (c) Such disclosure is reasonably necessary to complete the investigation of a Report;
- (d) Such disclosure is to the System senior executive (or his/her designee) who is charged with the oversight of duties, functions and responsibilities of the individual being investigated; or
- (e) Such disclosure is to the Governing Body and is necessary for the Governing Body to fulfill its fiduciary duty of care as it relates to the compliance oversight function.

(x) *Protecting the Integrity of an Investigation*

- (a) Compliance officer personnel and other OCC staff have an absolute obligation to protect the integrity of the investigatory process and take appropriate measures to limit the likelihood of Retaliation against Reporters and individuals who serve as witnesses or otherwise cooperate in the investigation of a Report.¹⁰²
- (b) Unless otherwise prohibited by applicable law, and subject to the considerations outlined in subparagraphs (e) and (f) of this

¹⁰¹ HCCA Code of Ethics for Health Care Compliance Professionals, Principle II, R2.5 (commentary).

¹⁰² See New York State Department of Health Office of the Medicaid Inspector General Compliance Program Guidance for General Hospitals (May 11, 2012), Element 7: Responding to Compliance Issues, Requirement 2 – Recommendation [E][1], p.31; *see also, generally*, 18 NYCRR 521.3; 2016 United States Sentencing Commission Guidelines Manual § 8B2.1 (b)(5)(C); Code of Ethics for Health Care Compliance Professionals, Principle II, R2.5

paragraph below, all Covered Persons and other individuals who are interviewed as part of an investigation into a Report shall, under the following circumstances, be informed and instructed by the interviewing compliance officer that they must refrain from discussing or otherwise disclosing the “the topic[s] and questions asked during the interview”¹⁰³ with any third party:

- Where necessary to preserve the integrity of the underlying investigation including, for example, to prevent:
 - the cover up of a Prohibited Act; or
 - the fabrication of witness testimony;
- Where the matter being investigated involves the possible falsification or tampering with official business records and the attendant facts and circumstances surrounding the corresponding Report warrant such an instruction;
- Where necessary to protect the confidentiality of patient information subject to HIPAA and other applicable patient confidentiality laws;
- Where necessary to protect the confidentiality of Workforce Member information under the Americans with Disabilities Act, Public Health Law, Labor Law, and other Workforce Member confidentiality laws;
- Where necessary to protect confidential proprietary, quality assurance, attorney-client privileged or other information afforded confidentiality protection under applicable Federal or State law;
- Where the matter being investigated concerns possible fraud, waste and abuse of a Federal healthcare program (*i.e.*, Medicaid and Medicare) or private payor funds including, without limitation, the submission of false claims, the commission of health care fraud or the engagement of improper referrals or activities involving kickbacks and the

¹⁰³ See New York State Department of Health Office of the Medicaid Inspector General Compliance Program Guidance for General Hospitals (May 11, 2012), Element 7: Responding to Compliance Issues, Requirement 2 – Recommendation [E][1], p.31 (providing that measures should be taken by compliance officer personnel “to protect the integrity of the interview process, including asking individuals to refrain from discussing the topic and questions asked during the interview. . .”).

attendant facts and circumstances surrounding the corresponding Report warrant such an instruction;

- Where necessary to protect Reporters and witnesses from Retaliation;
- Where the matter being investigated concerns allegations of patient abuse or substandard patient care and such instruction is necessary to protect the safety of patients who are Reporters or witnesses;
- Where necessary to prevent the destruction or tampering with records or other evidence that is potentially relevant to the investigation of a Report; or
- Where, based on the attendant facts and circumstances surrounding a Report, other legitimate and substantial System business interests exist that justify such instruction be given to an individual being interviewed in response to a Report.

Note: The interviewing compliance officer shall document the legitimate business interest that necessitated the issuance of a confidentiality instruction to an interviewee. In determining whether a confidentiality instruction should be given, the compliance officer must balance, on a case-by-case basis, the need for confidentiality to preserve the integrity of the investigation, or to further other legitimate and substantial system business interests as listed above, against the legally-cognizable protections for employees to discuss the terms and conditions of their employment.

- (c) All Covered Persons and other individuals who are interviewed as part of an investigation into a Report shall be informed by the interviewing compliance officer that retaliation against any witness, Reporter or other individual that cooperates or otherwise assists in the investigation of a Report is strictly prohibited and will subject the offending Covered Person to disciplinary action up to and including termination of employment, contract or other affiliation with the System.
- (d) The CCO, in consultation with Human Resources and OLA, shall request the removal of a Covered Person under investigation from his/her current work activity if the CCO “believes the integrity of

[an] investigation may be at stake because of the presence” of said Covered Person under investigation.¹⁰⁴

- (e) Nothing provided in subparagraph (b) of this paragraph shall in any way be construed to limit, restrict or otherwise alter the due process or other legal rights afforded under applicable Federal and State law to individuals being interviewed as part of a compliance investigatory process. Accordingly, during the conduct of investigative interviews, compliance officer personnel shall assure the legal rights of individuals related to the investigation that are recognizable under applicable law, collective bargaining agreement, employment contract, affiliation agreement or Vendor contract (*see* subdivision “B” of § 20 [**Contract Requirements**], *infra*, for the definition of the term “Vendor”).¹⁰⁵
- (f) Nothing provided in subparagraph (b) of this paragraph shall in any way be construed to limit witnesses from reporting possible violations of State or Federal law to regulatory oversight agencies and other government authorities, agencies or entities, or from making other disclosures that are protected under the whistleblower provisions of State or Federal law. Accordingly, the interviewing compliance officer shall ensure that the witness being interviewed is informed of their right to make such a report to government authorities. The compliance officer shall document such communication.

(xi) *Post Investigatory Actions*

Once an investigation into a Report has come to completion, compliance officer personnel shall determine the following with regard to investigations that yield credible evidence that a probable material commission of a Prohibited Act has in fact occurred:

- (a) Whether it is necessary to disclose the findings of the investigation to:
 - OMIG, CMS or OIG by way of each agency’s respective self-disclosure protocol;¹⁰⁶

¹⁰⁴ Department of Health and Human Services Office of Inspector General, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8998 (1998), § [II][G][1].

¹⁰⁵ *See* New York State Department of Health Office of the Medicaid Inspector General Compliance Program Guidance for General Hospitals (May 11, 2012), Element 7: Responding to Compliance Issues, Requirement 2 – Recommendation [E][2], p.31

¹⁰⁶ *See* New York State Office of the Medicaid Inspector General Compliance Program Review Guidance, *New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521*

- New York State Department of Health (“NYSDOH” or “DOH”) or other regulatory bodies;¹⁰⁷
 - Law enforcement;¹⁰⁸
 - Managed care organizations and other private payors;¹⁰⁹
- (b) Whether, as a result of the commission of a Prohibited Act, an overpayment exists that requires disclosure of and refunding to OMIG, OIG or private payors;¹¹⁰
- (c) Whether it is necessary to perform a root cause analysis of the Prohibited Act;
- (d) Whether the Prohibited Act requires intervention or further mitigation;
- (e) Whether the commission of the Prohibited Act in question necessitates supplementation to and/or changes in System-wide and/or program specific internal controls to prevent its reoccurrence;
- (f) Whether the matter that is the center of the Prohibited Act requires follow up including, for example, future reviews or audits;
- (g) Whether the revision of current policies and procedures is required; and
- (h) Whether focused System-wide training and education regarding the Prohibited Act is necessary.

Compliance Program Review Guidance (October 26, 2016), Guidance: Element 7 at 7.5 § (3)(b) and 7.6 (3)(b), p.28; *see also* 18 NYCRR 521.3 (c)(7)

¹⁰⁷ *See* New York State Office of the Medicaid Inspector General *Compliance Program Review Guidance, New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 7 at 7.5 § (3)(b), p.28; *see also* 18 NYCRR 521.3 (c)(7).

¹⁰⁸ *See* OIG, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8997 (1998), § [II][G][1];

¹⁰⁹ *See* New York State Office of the Medicaid Inspector General *Compliance Program Review Guidance, New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 7 at 7.5 § (3)(b), p.28; *see also* 18 NYCRR § 521.3 (c)(7).

¹¹⁰ *See also* New York State Office of the Medicaid Inspector General *Compliance Program Review Guidance, New York State Social Services Law section 363-d and Title 18 New York Code Rules and Regulations Part 521 Compliance Program Review Guidance* (October 26, 2016), Guidance: Element 7 at 7.6 § (1), p.28; *see* 18 NYCRR § 521.3 (c)(7).

15. ACCESS TO RECORDS

- A. Unless otherwise prohibited by applicable law, the CCO (and his/her subordinate compliance officer personnel) shall, to the extent that the CCO deems it necessary to carry out his/her compliance functions, duties, and obligations, be granted:
- (i) Unimpeded entry to any area or location within the System; and
 - (ii) Free and unfettered access to, and the authority to inspect, copy or remove records needed for an investigations:¹¹¹
 - (a) Any System document, log, file or other record that contains potentially relevant information regarding a compliance initiative, report, complaint, investigation, audit, review, inquiry or assessment; and
 - (b) Any System device that stores, houses or transmits potentially relevant information regarding a compliance initiative, report, complaint, investigation, audit, review, inquiry or assessment.
- B. Records that are necessary for patient care purposes may be removed by the CCO (and his/her subordinate compliance officer personnel) only if copies are made immediately available to the originating System facility, unit or entity. When original documents are removed by the CCO, they shall be returned as soon as possible.

16. EXECUTIVE ADMINISTRATIVE OVERSIGHT RESPONSIBILITIES

- A. With regard to their administrative oversight duties and functions, all System Corporate Officers, System Chief Executive Officers, and Presidents/Executive Directors (or other appointed principal administrative officer) of System subsidiaries, shall be responsible for, among other things, the following:
- (i) Providing ethical leadership and establishing a culture of compliance, ethics, and integrity and a tone from the top that demonstrates full support of the Program;¹¹²
 - (ii) Ensuring that all facilities, units and entities under their oversight operate, as applicable, in accordance with:

¹¹¹ See, generally, 63 Fed. Reg. 8987, 8994 (1998), § [II][B][1] (providing that “[t]he compliance officer must have the authority to review all documents and other information that are relevant to compliance activities”; see also, generally, HCCA Code of Ethics R3.2 [Commentary] (providing that “[c]ompliance personnel need free access to information to function effectively”).

¹¹² See 63 Fed. Reg. at 8988.

- (a) The NYC Health + Hospitals Principles of Professional Conduct (“POPC”);
 - (b) This OP and other compliance policies and procedures, as well as all other System policies;
 - (c) All applicable Federal and State laws, rules and regulations; and
 - (d) All applicable Federal health care programs and private payor requirements.
- (iii) Establishing and implementing directive, detective, preventive, and corrective internal controls, as well as corresponding systems, practices and procedures, to facilitate ethical and legal conduct;
 - (iv) Fairly and consistently enforcing, with the assistance of, and together with, Talent Acquisition and Labor Relations, the System’s disciplinary policy outlined in § 23 [**Disciplinary Policy**], *infra*;
 - (v) Encouraging and supporting Compliance Reporting;
 - (vi) Mandating Workforce Member completion of System training programs;
 - (vii) Ensuring and facilitating the CCO’s (and other compliance staff) unaccompanied access to all facility Workforce Members as the CCO deems necessary to conduct internal investigations, audits, reviews and other compliance functions and activities relevant to the Program; and
 - (viii) Protecting whistleblowers, as outlined in subdivision “A” of § 24 [**Retaliation Prohibited/Whistleblower Protection**], *infra*, by committing to a zero tolerance policy when it comes to any retaliatory activity stemming from making Reports of Compliance Concerns or participating in compliance investigations, reviews or audits.

17. STANDARDS OF CONDUCT

A. Principles of Professional Conduct

- (i) All Covered Persons are required to adhere to the *NYC Health + Hospitals Principles of Professional Conduct* (“POPC”). As first noted in paragraph (v) of subdivision “B”, § 7 [**Attachments**], *supra*, the POPC is a guide that sets forth NYC Health + Hospitals compliance expectations and commitment to comply with all applicable Federal and State laws. The

POPC also describes the System’s standards of professional conduct and efforts to prevent fraud, waste, and abuse.¹¹³

B. Conflicts of Interests

- (i) All System employees, Members of the NYC Health + Hospitals Board of Directors, and Directors of the System’s wholly owned subsidiaries are required to adhere to Chapter 68 of the New York City Charter.¹¹⁴
- (ii) All System affiliate employees (*e.g.*, S.U.N.Y. Downstate, PAGNY, Mount Sinai, and NYU) (*see* paragraph (iii) of subdivision “A” of § 6, *supra*, for the definition of “affiliate employees”) are required to adhere to the NYC Health + Hospitals Code of Ethics.¹¹⁵ Members of the System’s Community Advisory Board and Auxiliary and other personnel who are not covered by Chapter 68 are also subject to the Code of Ethics.¹¹⁶
- (iii) All System employees shall comply with OP 20-55 (*Pharmaceutical Company Gifts and Sponsored Educational Programs*), which sets forth the obligations of these individuals as they relate to gifts from pharmaceutical and other companies that provide or intend to provide supplies and/or equipment to the System.¹¹⁷

By way of the System’s POPC, as well as the obligations set forth under Chapter 68, all members of the System’s Board of Directors and Directors of the System’s wholly owned subsidiaries who are not directly covered under OP 20-55, are subject to the same restrictions outlined in OP 20-55.¹¹⁸

¹¹³ The POPC is attached hereto for reference purposes as Attachment “V-a”. To assist Covered Persons to better understand their responsibilities under the POPC, the OCC has developed *NYC Health + Hospitals Principles of Professional Conduct Frequently Ask Questions (“FAQs”)* (“POPC FAQs”), which is attached hereto as Attachment “V-b.”

¹¹⁴ Chapter 68 may be found at: http://www.nyc.gov/html/conflicts/downloads/pdf2/books/blu_bk.pdf. A two page summary of Chapter 68 is attached hereto as Attachment “VI – *New York City Conflicts of Interest Board, New York Conflicts of Interest Law, Covering New York City Public Servants (Plain Language Version)*.”

¹¹⁵ *See* NYC Health + Hospitals By-laws (the “By-laws”) at Article XIX [Conflicts of Interest].

¹¹⁶ *See id.* Note that, the NYC Health + Hospitals Code of Ethics may be accessed at:

<http://www.nychealthandhospitals.org/wp-content/uploads/2016/07/HHC-Code-of-Ethics-1.pdf>. A summary of the Code of Ethics is annexed hereto as Attachment “VII” - *NYC Health + Hospitals Code of Ethics Summary of Key Provisions*. Note that, although the Code of Ethics states that it applies to the System’s “Board of Directors, its Officers, and employees (including medical staff), Corporation Hospital Auxiliaries, members of the Corporation’s Community Advisory Boards, and covered affiliate personnel”, this application is superseded by Article XIX [Conflicts of Interest] of the System’s By-laws, which specifically limits the application of the Code of Ethics to “all members of the [System’s] community advisory boards and its auxiliaries, and other personnel who are not covered by Chapter 68.” The term “other personnel”, as used in the By-laws, includes, without limitation, all affiliate employees.

¹¹⁷ OP 20-55 (*Pharmaceutical Company Gifts and Sponsored Educational Programs*). OP 20-55 may be accessed on the System’s public webpage at: <http://www.nychealthandhospitals.org/wp-content/uploads/2016/07/OP20-55.pdf>.

¹¹⁸ *See* POPC §§ III (at bullets ## 6 and 11) and VI (at bullet # 10).

Likewise, by way of the System’s By-laws and Code of Ethics, all affiliate employees, members of the System’s Community Advisory Board and Auxiliary, and other System personnel who are not directly covered under OP 20-55, are subject to the same restrictions outlined in OP 20-55.¹¹⁹

Note: Section VI [**What are Some Examples of Unprofessional Conduct**] of the POPC (*see* Attachment V-a), which is applicable to all Covered Persons, prohibits the acceptance of gifts from a vendor or potential vendor.

- (iv) All Covered Persons shall comply with OP 20-54 (*Nepotism*), which, with regard to Covered Persons who serve in a supervisory role or capacity at the System, sets forth the restrictions that Covered Persons are subject to as they relate to the supervision of relatives. OP 20-54 also prohibits two or more relatives who work in the same facility from working in the same unit regardless of whether a supervisory relationship exists.¹²⁰

C. Social Media Use

All Workforce Members shall comply with OP 20-61 *Social Media Use*, which serves as a guide to help Workforce Members:

- (i) Appropriately use social media; and
- (ii) Identify and avoid potential issues related to the use of social media.

18. WORKFORCE TRAINING AND EDUCATION

A. Policy

It is the Policy of the System to take reasonable steps to periodically communicate aspects of the Program by conducting effective compliance training and education programs (hereinafter “Compliance Training” or “Training”) and otherwise disseminating information appropriate to the respective roles and responsibilities of affected Covered Persons.

B. Training Frequency

- (i) All affected Covered Persons shall receive Compliance Training as part of their orientation to the System.¹²¹ Additionally, affected Covered Persons

¹¹⁹ See OP 20-55 § [3][I]; *see also* the System’s By-laws at Article XIX [Conflicts of Interest].

¹²⁰ See OP 20-54 (*Nepotism*). Note that, in addition to Covered Persons, OP 20-54 also covers any individual or entity that serves in a supervisory role or capacity at the System.

¹²¹ See Social Services Law 363-d [2][c]; *see also, generally*, 63 Fed. Reg. 8987, 8994, § [II][c] (1998) (providing that “[n]ew new employees shall be targeted for training early in their employment.”).

shall subsequently receive further Training at periodic intervals, which shall occur at least on an annual basis.¹²²

- (ii) All Workforce Members who are granted access to any NYC Health + Hospitals medical record or patient billing system shall complete the Training outlined in subdivision “C” of this Section, *infra*, prior to being granted access to such information systems.

C. Training Content

- (i) All Covered Persons shall receive Compliance Training covering, among other topics, the following:
 - (a) Pertinent System policies, procedures, and standards of conduct;
 - (b) Compliance issues, concerns, and risk areas;¹²³
 - (c) Compliance program operations and expectations;¹²⁴
 - (d) The Deficit Reduction Act of 2005 including, without limitation fraud, waste and abuse laws, Federal and State False Claims Acts and Whistleblower protection laws;
 - (e) Medicare Advantage Parts C and D training and education, as determined by CMS; and
 - (f) Any other topic required by applicable Federal or State law, or by third party contract or other agreement.
- (ii) In addition to the Training outlined in paragraph (i) of this subdivision, *supra*, all Workforce Members shall receive compliance training and education covering Federal and State patient information privacy and security requirements including, without limitation, those requirements set forth under:
 - (a) The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and Health Information Technology for Economic and Clinical Health Act (“HITECH”) provisions of the American Recovery and Reinvestment Act of 2009 including, for example, confidentiality, security awareness, and breach notification;¹²⁵

¹²² See Social Services Law 363-d [c] (calling for compliance training to occur “periodically.”)

¹²³ See Social Services Law § 363-d [2][c]; 18 NYCRR § 521.3 [c][3]; see also 63 Fed. Reg. 8987, 8994, § [II][C] (1998).

¹²⁴ Social Services Law § 363-d [2][c]; 18 NYCRR § 521.3 [c][3]; 63 Fed. Reg. 8987, 8994, § [II][C] (1998).

¹²⁵ See 42 USC. § 1320d & 42 CFR Parts 160 & 164; see also 42 USC. § 17921; 42 U.S.C. §§ 17931- 17940.

- (b) 42 U.S.C. § 290dd-2 and 42 CFR Part 2, (confidentiality of substance use disorder patient records)¹²⁶;
- (c) Public Health Law §§ 18 (confidentiality of patient information), 2803-c (patient right to confidentiality), and 2805-g (confidentiality of medical, social, personal and financial patient information);¹²⁷
- (d) Article 27-F of the New York Public Health Law (confidentiality of confidential HIV-related information)¹²⁸;
- (e) New York Mental Hygiene Law §§ 22.05 and 33.13 (confidentiality of patient information pertaining to the treatment of a mental illness found in a clinical record);¹²⁹ and
- (f) Article 79-1 of the New York Civil Rights Law (confidentiality of predisposition genetic testing).¹³⁰

The CCO shall also provide patient and other information privacy and security training to other Covered Persons, individuals and entities that access, store, house, transmit or otherwise use NYC Health + Hospitals confidential patient, Covered Person or business information where: (i) the CCO determines that, based upon the performance and corresponding results of a formal risk analysis, such training is necessary; or (ii) such training is required by internal policy or applicable Federal or State law.

- D. The CCO shall, in his/her sole discretion, determine the modes of training necessary to fulfill the requirements of this section. Such modes of training may include the following or any combination thereof:
 - (i) The development of web-based or computerized training modules;
 - (ii) Live interactive training;¹³¹

¹²⁶ See 42 USC § 290dd-2 & 42 CFR Part 2; see also 42 CFR §§ 8.11 [f][3], 8.12 [g][1].

¹²⁷ See Public Health Law §§ 18 [3][i], [6] (providing, in sum and substance, that patient information may only be disclosed where: (i) a legislative or other legal exception exists; and (ii) such disclosure is either accompanied by (a) the written authorization of the patient or other qualified person or (b) a note that is documented in the patient record detailing the name and address of the intended recipient of the patient information and the purpose of the disclosure and such purpose must be authorized under the existing legislative or other legal exception), [10] (highlighting, among other things, the applicability of the various healthcare provider-patient privileges under Article 45 of the CPLR), 2803-c [1], [3][f] (patient right to confidentiality), 2805-g [3] (confidentiality of medical, social, personal, and financial information of patients).

¹²⁸ See Public Health Law §§ 2780-2787 *et seq.* and 10 NYCRR part 63; see also 10 NYCRR § 63.9 [a].

¹²⁹ See Mental Hygiene Law §§ 22.05 and 33.13.

¹³⁰ See Article 79-1 of the Civil Rights Law.

¹³¹ See 63 Fed. Reg. 8987, 8994, § (II)(c)[1998].

- (iii) The incorporation of compliance training into existing training and education programs; or
 - (iv) The dissemination of training materials to affected Covered Persons including, for example, focused memoranda, PowerPoint presentations, bulletins, internal notices, System-wide alerts, and reading materials.
- E. The CCO shall, in his/her sole discretion, determine the content of training and education materials acceptable to meet the requirements of this section. All compliance training and education materials shall be approved by the CCO.
- F. All formal Training conducted throughout the System as part of the Program shall be documented and maintained by the OCC.¹³²

19. INFORMATION GOVERNANCE

- A. With regard to privacy, data security, and record management, the System is committed to:
- (i) Maintaining accurate records of all of its operations in a manner that ensures both the accessibility of information created and received in the normal course of business, and the confidentiality and security of patient, employee, and other sensitive and/or confidential information that is:
 - (a) Under the System's possession, custody, and control; and/or
 - (b) Created, maintained, processed, and/or transmitted by the System;
 - (ii) Ensuring that all System records are available when needed and are authentic, consistent, and accurate;
 - (iii) Complying with all applicable Federal and State patient and employee privacy and confidentiality laws (hereinafter collectively "Confidentiality Laws");
 - (iv) Providing Workforce Member training, education, and guidance regarding Confidentiality Laws; and
 - (v) Ensuring the systematic retention, storage, disposition, and destruction of the System's records in an organized and orderly fashion in accordance with internal policies and procedures and applicable law.
- B. In addition to carrying out their functions, duties, and responsibilities in a manner that permits the System to meet its policy commitments outlined hereinabove in

¹³² See *id.*

subdivision “A” of this section, all Workforce Members must adhere to the following System policies:

- (i) The System’s Record Management Program set forth under OP 120-19 (*Guidelines for Corporate Record Retention and Disposal*);
- (ii) The HIPAA Privacy Program and related patient confidentiality policies and procedures in the 240 Series of NYC Health + Hospitals’ Operating Procedures;¹³³
- (iii) The HIPAA Security Program policies and procedures found in the 250 Series of NYC Health + Hospitals’ Operating Procedures;¹³⁴ and
- (iv) The security policies found on the NYC Health + Hospitals Enterprise Information Technology Services (“EITS”) security homepage, including but not limited to, policies that govern asset management, access control, and security incident response.

20. CONTRACT REQUIREMENTS

A. Policy Statement

All contracts with Vendors, as that term is defined in subdivision “B” of this section, shall:

- (i) Provide for Vendor participation in and compliance with the Program including:
 - (a) Compliance with this OP and related compliance policies including, without limitation, the compliance OPs found under the 50 series of NYC Health + Hospitals OPs; and
 - (b) The NYC Health + Hospitals POPC; and
- (ii) Include provisions that allow for the imposition of Disciplinary Action, as described below in § 23 [**Disciplinary Policy**], for vendors who fail to comply with this OP.

B. Vendor Defined

For purposes of this OP the term “Vendor” shall collectively include any vendor, contractor, subcontractor or other third-party that, by way of agreement, affiliation

¹³³ The 240 series of OPs are available on the System’s intranet at:
<http://hbcinsider.nychhc.org/corpoftices/syswidePnP/Pages/Index.aspx> .

¹³⁴ The 250 series of OPs are available on the System’s intranet at:
<http://hbcinsider.nychhc.org/corpoftices/syswidePnP/Pages/Index.aspx> .

or other contract with the System, serves as (or provides) a Workforce Member, Business Partner, or Agent for the System.

C. Responsibilities

The offices listed in paragraphs (i) and (ii) below shall have the following responsibilities as they relate to implementing the requirements of subdivision “A” of this section, *supra*:

- (i) The Office of Legal Affairs (“OLA”) shall draft, negotiate or otherwise approve as to acceptability as to legal form the contractual language necessary to meet the requirements set forth in subdivision “A” of this section, *supra*.
- (ii) The Office of Supply Chain shall establish internal systems, practices, procedures, and controls to ensure that all Vendor contracts meet the requirements set forth in subdivision “A” of this section, *supra*.

21. MANDATORY COMPLIANCE

All Covered Persons are responsible for complying with:

- A. This OP including, without limitation, the provisions found under § 12 [**Responsibilities of All Covered Persons**] of this OP, *supra*;
- B. All applicable Federal and State laws; and
- C. All applicable Federal healthcare program requirements and conditions of participation, as well as applicable private payor requirements.

22. MANDATORY REPORTING AND COMPLIANCE WITH INVESTIGATIONS

A. Mandatory Reporting

NYC Health + Hospitals places an affirmative responsibility and obligation on all Covered Persons to report to the OCC (*see* reporting procedures outlined below in subdivision “B” of this section) the commission of (or any attempt to commit or conspiracy or other plan to commit) any Prohibited Act (*see* subdivisions of “B” and “D” § 23 [**Disciplinary Policy**], *infra*) that is brought to their attention or that they otherwise become aware of.

B. Reporting Procedure

All Compliance Reporting shall be made to the OCC via the NYC Health + Hospitals Compliance Helpline; telephone or fax; email; or by letter as follows:

**NYC Health + Hospitals
Office of Corporate Compliance
160 Water Street, Suite 1129
New York, NY 10038
Telephone: (646) 458-7799
Facsimile: (646) 458-5624
E-mail: COMPLIANCE@nychhc.org
Confidential Compliance Helpline:
1-866-HELP-HHC (1-866-435-7442)**

OneCity Health DSRIP Compliance Helpline (for DSRIP-related compliance issues):

1-844-805-0105

MetroPlus Health Plan Compliance Hotline (for MetroPlus compliance issues):

1-888-245-7247

C. Cooperation with Investigations

All Covered Persons must participate and/or cooperate in good faith with any investigation into a reported violation of the Program, be truthful with investigators, preserve documentation and/or records relevant to ongoing investigations as set forth under OP 120-19, and they must also provide the CCO (or his/her designee) access to all System records in their possession, custody and control as directed by the CCO.

D. Sanctions for Non-compliance

Failure to report a known 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 up to and including termination of employment, contract or other affiliation with the System as set forth in the Disciplinary Policy in § 23, *infra*. Likewise, any Covered Person that attempts to interfere with or influence the outcome of a compliance investigation shall be subject to disciplinary action.

23. DISCIPLINARY POLICY

A. Disciplinary Policy Statement

The System is committed to:

- (i) Implementing disciplinary policies, procedures, and practices as are necessary to:

- (a) Encourage good faith participation in the Program including, for example, policies and procedures that articulate expectations for Compliance Reporting and resolving compliance issues;¹³⁵ and
 - (b) Prevent or reduce the likelihood of the reoccurrence of “Prohibited Acts”, as that term is defined in subdivisions “B” and “D” of this section, *infra*;
- (ii) Applying appropriate sanctions against Covered Persons that fail to comply with applicable law and internal System policies and procedures;¹³⁶ and
 - (iii) Ensuring that System senior administrators, managers, and supervisors, as part of their work duties and functions, establish a work environment that encourages Compliance Reporting without fear of retaliation.¹³⁷

B. Overview

The failure by a Covered Person to comply with and/or affirmatively participate in the Program, or the engagement of a Covered Person in conduct that otherwise constitutes wrongdoing (collectively hereinafter referred to as “Prohibited Acts”), shall result in sanctions or other disciplinary action (hereinafter collectively referred to as “Disciplinary Action”) as described in subdivision “C” of this section, *infra*.¹³⁸

C. The Application of Disciplinary Action

- (i) Covered Persons shall be subject to Disciplinary Action up to and including termination of employment, contract or other affiliation with the System for engaging in Prohibited Acts.

¹³⁵ See Social Services Law § 363-d [2][e]; 18 NYCRR § 521.3[c][5].

¹³⁶ See Social Services Law 363-d [2][e] (disciplinary requirements under the State’s mandatory provider compliance programs); 18 NYCRR § 521.3 [c][5] (same); *see also*, 63 Fed. Reg. 8987, 8995, § [II][E][1] (1998) (stating that “[a]n effective compliance program should include guidance regarding disciplinary action for corporate officers, managers, employees, physicians and other healthcare professionals who have failed to comply with the hospital’s standards of conduct, policies and procedures, Federal and State laws, or have otherwise engaged in wrongdoing”); OIG, Publication of the OIG Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14289, 14303, § [II][G][1] (2000) (same); 42 CFR § 483.85 [c][7](compliance program disciplinary requirements for long-term care facilities); 80 Fed. Reg. 42167, 42219 as finalized at 81 Fed. Reg. 68668, 68813 (2016) (same); 45 CFR §§ 164.308 [a][1][ii][C] and 164.530 [e][1] (sanction requirements for violations of the HIPAA Security Rule and Privacy Rule, respectively); 42 CFR § 422.503 [b][4][vi][A]; Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines (Rev. 110, 01-11-13), § 50.5; HRSA Health Center Program – *Health Center Compliance Manual*, Chapter 13: Conflict of Interest [*Requirements and Demonstrating Compliance* sections](disciplinary requirements for FQHCs) available at: <https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf>.

¹³⁷ See 63 Fed. Reg. 8987, 8996, § [II][E][1], (1998) (stating that “[t]he OIG believes that [workforce members] should be held accountable for failing to comply with, or for the foreseeable failure of their subordinates to adhere to, the applicable standards, laws, and procedures.”).

¹³⁸ See, generally, 63 Fed. Reg. 8987, 8995-6, § [II][E][1] (1998).

- (ii) Subject to the limitations and other considerations outlined in ¶ (viii) of this subdivision, Disciplinary Action may be:
 - (a) Informal in nature and involve corrective coaching, educational, training, and/or remedial actions and measures; and/or
 - (b) Formal in its application and may result in adverse employment, contractual or other actions taken by the System against a Covered Person.

- (iii) Examples of Disciplinary Action that a Covered Person may face for engaging in a Prohibited Act include, but are not limited to:
 - (a) Education, retraining or corrective coaching;
 - (b) Oral or written warnings regarding the Prohibited Act;¹³⁹
 - (c) Counseling;¹⁴⁰
 - (d) Financial penalties;¹⁴¹
 - (e) Demotion in grade or title;¹⁴²
 - (f) Suspension without pay;¹⁴³
 - (g) The revocation of privileges as provided under the applicable facility Medical Staff By-laws;¹⁴⁴ and
 - (h) Termination of employment, contract or other affiliation with the System.¹⁴⁵

¹³⁹ See *id.* at 8987, 8995-6, § [II][E][1], (1998); see also OIG, *Publication of the OIG Compliance Program Guidance for Nursing Facilities*, 65 Fed. Reg. 14289, 14303, [II][G][1], (2000); New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5 (a), available at: http://eig.nychhc.org/upload/MyDocuments/PersonnelRuleandRegs_opt.pdf.

¹⁴⁰ See OP 20-10 (Employee Performance and Conduct), § [IV][A], p.2.

¹⁴¹ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals* 63 Fed. Reg. 8987, 8995-6, § [II][E][1], (1998); see also Fed. Reg. at 14303; New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5 (b).

¹⁴² New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5 (d).

¹⁴³ See 63 Fed. Reg. 8987, 8995-6, § [II][E][1], (1998); see also New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5 (c).

¹⁴⁴ See 63 Fed. Reg. 8987, 8995-6, § [II][E][1], (1998).

¹⁴⁵ See 63 Fed. Reg. 8987, 8995-6, § [II][E][1], (1998); see also 65 Fed. Reg. 14289, 14303 (2000); New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5(e).

- (iv) Disciplinary Action shall be enforced fairly and shall be applied consistently across the System to all Covered Persons regardless of rank, profession, title, duty or function.¹⁴⁶ All Covered Persons shall potentially face the same level of Disciplinary Action for the commission of similar Prohibited Acts.¹⁴⁷
- (v) Workforce Member supervisors and/or managers can be held accountable for the foreseeable compliance failures of their subordinates.¹⁴⁸
- (vi) Each commission of a Prohibited Act must be considered on a case-by-case basis when determining the appropriate course of Disciplinary Action that should be undertaken in response to such wrongdoing.¹⁴⁹ The Disciplinary Action imposed shall be based on the nature and severity of the violation or misconduct.¹⁵⁰
- (vii) When imposing discipline, one factor that may be considered is whether the Prohibited Act committed was part of a pattern or practice or an isolated incident.¹⁵¹ Another factor that may be considered is whether the Prohibited Act was intentional or unintentional.¹⁵² For example, intentional or reckless noncompliance with applicable laws and internal policies, as well as noncompliance resulting from known conflicts of interests or from personal benefits gained by way of a Prohibited Act, is likely to result in significant Disciplinary Action.¹⁵³ Generally, the System will most often seek (as applicable and subject to the limitations and other considerations outlined in ¶ (viii) of this subdivision, *infra*) immediate and prolonged suspension, revocation of privileges, reporting to State licensing boards (*see* ¶ (ix) of this subdivision, *infra*), and/or the termination of an employment, contractual or affiliation relationship in instances in which a Covered Person commits a Prohibited Act that has affected or may affect:

¹⁴⁶ See 63 Fed. Reg. 8987, 8996, § [II][E][1] (1998) (“The consequences of noncompliance should be consistently applied and enforced, in order for the disciplinary policy to have the required deterrent effect. All levels of employees should be subject to the same disciplinary action for the commission of similar offenses.”); *see also* 65 Fed. Reg. 14289, 14303 (2000).

¹⁴⁷ See 65 Fed. Reg. 14289, 14303 (2000), § [II][G] (providing that “[a]ll levels of employees should be potentially subject to the same types of disciplinary action for the commission of similar offenses”).

¹⁴⁸ See 65 Fed. Reg. 14289, 14299, 14303; 63 Fed. Reg. 8987, 8996 (1998), § [II][E][1].

¹⁴⁹ See 63 Fed. Reg. 42410, 42422 (1998), § [II][E][1] (stating that, with regard to instances of noncompliance, “[e]ach situation must be considered on a case-by-case basis to determine the appropriate sanction.”); *see also* 65 Fed. Reg. 14289, 14303 (2000), § [II][G] (same).

¹⁵⁰ See 65 Fed. Reg. 82462, 82562 (2000); *see also, generally*, 63 Fed. Reg. 8987, 8995-8996, (1998) § [II][E][1].

¹⁵¹ See 65 Fed. Reg. 82462, 82562 (2000).

¹⁵² See 65 Fed. Reg. 82462, 82562 (2000); *see also, generally*, 63 Fed. Reg. 8987, 8995, § [II][E][1] (1998) (providing that “[i]ntentional . . . noncompliance should subject transgressors to significant sanctions.”); 65 Fed. Reg. 14289, 14303 (2000), § [II][G][1] (same).

¹⁵³ See, *generally*, 63 Fed. Reg. 8987, 8995 (1998), § [II][E][1].

- (a) Patient, workplace, or environmental safety within the System (*e.g.*, conduct that amounts to patient abuse; the provision of clinical or other health services without an appropriate license where such a license is required by applicable law; intentional or reckless conduct that results (or has the potential to result) in serious injury or other harm to patients and/or Workforce Members; and the improper and unsafe disposal of toxic, hazardous, radioactive, and pharmacological agents, materials, instruments and supplies);
- (b) The mission of the System to maintain a discrimination free patient care and work environment (*e.g.*, conduct involving the refusal to provide care, or the provision of substandard patient care, based on a patient's race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or any other protected characteristic covered by Federal, State or local anti-discrimination laws; or acts of discrimination in the workplace based on race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or any other protected characteristic covered by Federal, State or local anti-discrimination laws);
- (c) The integrity of the System's efforts to combat fraud, waste, abuse, theft, and corruption (*e.g.*, intentional or reckless violations (or attempted violations) of fraud, waste and abuse laws including, without limitation, the submission of false claims and the failure to return identified overpayments; the concealment or cover up of a civil or criminal violation of law or internal policy or procedure; the falsification of official System business records including, without limitation, medical records, billing records, employment records, and financial records; the theft of System property; the acceptance or offering of bribes or kickbacks or the engagement of official misconduct or other corrupt activities; the refusal to cooperate with an internal compliance investigation or other review; the engagement of conduct intended to thwart, stifle, suppress or otherwise interfere with an internal or external investigation into possible Program violations; and violations of the System's anti-retaliation/whistleblower protection policies);
- (d) The System's privacy and data security initiatives and employee and patient information confidentiality (*e.g.*, the unauthorized access, use or disclosure of System confidential information such as, for example, patient or confidential employee information, quality assurance information, proprietary information or information covered under the attorney-client privilege or other legally recognizable privileges, for monetary purposes or other personal gains or interests, or out of malice or to damage the reputation of the

individual or entity to whom the confidential information pertains; or the commission of acts that violate Federal or State employee or patient confidentiality laws (and/or related internal System policies and procedures) and results in (or could result in) a breach of confidential information especially where such breach is significant and could lead to, or results in, harm to the affected individual or the System).

- (viii) Any Disciplinary Action taken against a Covered Person that engages in a Prohibited Act shall be in accordance with applicable Federal and State laws and, as appropriate, the terms, conditions, and other provisions found in all applicable documents governing the relationship or other affiliation between the System and a Covered Person (*e.g.*, employment contracts; vendor contracts; collective bargaining agreements; NYC Health + Hospitals Personnel Rules and Regulations and other System internal human resources and labor policies; affiliation arrangements; medical staff by-laws; or memoranda of understandings). Accordingly, notwithstanding anything stated hereunder to the contrary, the term “Disciplinary Action” as used in this OP is not intended to replace, modify, change or otherwise alter the definition of the same or similar term as it may be found in applicable collective bargaining agreements, employment or third-party contracts.
- (ix) Where required by applicable law or internal policy, Disciplinary Action may trigger or include external reporting of certain misconduct to outside governmental entities including, but not limited to, the Office of Professional Misconduct (“OPMC”) and Office of Professional Discipline (“OPD”).¹⁵⁴

D. Prohibited Acts

The engagement of Prohibited Acts by a Covered Person constitutes a failure to affirmatively participate in the Program. Prohibited Acts include, for example, any of the following:

- (i) Failing to conduct themselves in a legally compliant and ethical manner;
- (ii) Failing to report suspected compliance issues, problems, complaints, and incidents;¹⁵⁵

¹⁵⁴ See *e.g.*, Public Health Law § 230 [11][a] (required reporting to the New York State Board for Professional Medical Conduct of any information “which reasonably appears to show that a licensee is guilty of professional misconduct as defined in sections sixty-five hundred thirty and sixty-five hundred thirty-one of the education law.”) and Public Health Law §2803-e [1]); see also 65 Fed. Reg. 14289, 14304 (the nursing facility “should promptly report the existence of misconduct to the appropriate Federal and State authorities within a reasonable period, but not more than 60 days after determining that there is credible evidence of a violation.”).

¹⁵⁵ See Social Services Law § 363-d [2][e][1]; 18 NYCRR §521.3[c][5][i]; New York State Department of Health, Office of the Medicaid Inspector General, *Compliance Program Guidance for General Hospitals* (May 11, 2012),

- (iii) Participating in non-compliant behavior, such as, for example, failing to comply with this OP or with any other applicable System OP or other policy or procedure (*e.g.*, System privacy policies and procedures);¹⁵⁶
- (iv) Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;¹⁵⁷
- (v) Failing to comply with the POPC;
- (vi) Failing to complete assigned training and education programs;
- (vii) Failing to comply with applicable Federal and State laws (*e.g.*, engaging in criminal or unlawful/illegal conduct including, without limitation, conduct in violation of healthcare fraud, waste and abuse laws) and/or Federal health care program and private payer requirements;
- (viii) Engaging in “Retaliation”, as that term is defined in subdivision “C” of § 24 [**Retaliation Prohibited/Whistleblower Protection**], *infra*, against any person who reports (or threatens to report) actual or suspected Program violations;
- (ix) Refusing to cooperate with an internal investigation, audit, review or inquiry;¹⁵⁸
- (x) Failing to cooperate with government investigators or other regulatory enforcement bodies;
- (xi) Failing to be truthful to internal or external investigators;¹⁵⁹
- (xii) Failing to report a matter to government officials or regulatory oversight agencies when required by Federal or State law to do so;
- (xiii) Failing to preserve documentation and records relevant to internal or external ongoing investigations;¹⁶⁰
- (xiv) Engaging in conduct that violates professional or clinical standards and/or obligations;¹⁶¹

Element 5, Requirement 2, Recommendations § (A)(1).

¹⁵⁶ See Social Services Law § 363-d [2][e][2]; 18 NYCRR § 521.3[c][5][ii].

¹⁵⁷ See Social Services Law § 363-d [2][e][3]; 18 NYCRR § 521.3[c][5][iii].

¹⁵⁸ New York State Department of Health, Office of the Medicaid Inspector General, *Compliance Program Guidance for General Hospitals* (May 11, 2012), Element 5, Requirement 1, Recommendations § [B][1][b].

¹⁵⁹ *Id.* at Element 5, Requirement 1, Recommendations § [B][1][c].

¹⁶⁰ *Id.* at Element 5, Requirement 1, Recommendations § [B][1][d].

¹⁶¹ See, generally, 45 CFR § 164.502 (j)(1)(i); see also, generally OIG, *OIG Supplemental Compliance Program Guidance for Hospitals*, 70 Fed. Reg. 4858, 4874, § [III][A] (2005).

- (xv) Furnishing care and services, and/or the creation or sanctioning of conditions, that potentially endanger patients, Workforce Members, or the public;¹⁶²
- (xvi) Accessing, disclosing, transmitting, or otherwise using the following confidential System information in a manner that is inconsistent with Federal and State Law or the System’s internal information governance policies or contractual requirements (*e.g.*, business associate agreement, qualified service organization agreement, and other contractual provisions that govern the use of confidential information):
 - (a) Patient protected health information;
 - (b) The personally identifiable information and/or private information of Covered Persons; and
 - (c) System business information that is protected under legally recognizable privileges or applicable confidentiality laws, or is otherwise not subject to public disclosure;
- (xvii) Failing to satisfy the responsibilities outlined in subdivision “A” of § 12 [**Responsibilities of All Covered Persons**], *supra*; and
- (xviii) Engaging in any activity that has the potential to interfere with or otherwise negatively affect the policy objectives and purposes of the Program outlined in §§ 3 [**Policy**] and 4 [**Purpose**], respectively, *supra*.

E. Implementation

- (i) Where a compliance investigation (including matters investigated under the direction or at the request of the OCC as set forth in subdivision “B” of § 14 [**Procedures of the CCO and Other Compliance Personnel**], *supra*) of a matter (or a matter that was investigated by another department that involved allegations of fraud, waste, and abuse; violations of information governance policies; conflicts of interests; conduct that could lead to the possible imposition of civil monetary penalties; violations of the human subject research policies and procedures; or other significant violations of the POPC¹⁶³) results in a finding that credible evidence exists of a probable material commission of a Prohibited Act by a Covered Person, the CCO (or

¹⁶² See, generally, 45 CFR § 164.502 (j)(1)(i).

¹⁶³ Note: The OCC shall be immediately notified (*see* § 22 [**Mandatory Reporting and Compliance with Investigations**], *supra*) of allegations involving fraud, waste, and abuse; violations of information governance policies; conflicts of interests; conduct that could lead to the possible imposition of civil monetary penalties; violations of the human subject research policies and procedures; or other significant violations of the POPC.

his/her designee) shall provide guidance on the Disciplinary Action to be considered by, as applicable:¹⁶⁴

- (a) Human Resources and/or Labor Relations with respect to employees;
 - (b) The Office of Affiliations, Human Resources, OLA, and the corresponding facility Chief Executive Officer with respect to affiliate employees; and
 - (c) Supply Chain and OLA, and where necessary, Human Resources (*e.g.*, where a vendor provides Workforce Members to the System to carryout System activities), with regard to Vendors (except for affiliates).
- (ii) In addition to the departments outlined above in subparagraphs (a-c) of ¶ (i) of this subdivision, guidance on Disciplinary Action may be made by the CCO, Corporate or Facility Chief Medical Officer, OLA, or Human Resources to the applicable Medical Staff Board President (or other individual authorized in the corresponding medical staff by-laws to receive and act on provider complaints) with respect to members of the medical staff who have engaged in a Prohibited Act. Any corresponding action taken by the Medical Board shall be pursuant to and in compliance with the procedures, processes, and rules set forth in applicable medical staff by-laws.
- (iii) With the advice and counsel of the OLA (and in consultation with the OCC), Human Resources, Labor Relations, Office of Affiliations, and Supply Chain shall establish uniform System-wide internal policies, procedures, and practices to implement the System's Disciplinary Action policy outlined in this section.
- (iv) The OCC shall monitor the System-wide application of the requirements found in this section to assess fair and consistent application of Disciplinary Action imposed on Covered Persons who commit a Prohibited Act.
- (v) Each matter involving the enforcement of disciplinary standards shall be expeditiously undertaken and thoroughly documented.¹⁶⁵
- (xix) The System's Disciplinary Action policy shall be prominently publicized and made readily accessible to all Covered Persons.¹⁶⁶

¹⁶⁴ See 63 Fed. Reg. 8987, 8995 (1998).

¹⁶⁵ See 70 Fed. Reg. 4858, 4876, § [III][B][7] (2005).

¹⁶⁶ See *id.*

24. RETALIATION PROHIBITED/WHISTLEBLOWER PROTECTION

A. Retaliation Prohibited/Whistleblower Protection

The System strictly prohibits intimidation and retaliation, in any form, against any Covered Person or other individual or entity that, in good faith, participates in the Program by engaging in any of the following activities (hereinafter collectively referred to as “Protected Conduct”):

- (i) Reporting and investigating potential compliance issues and other concerns including, without limitation, those surrounding the engagement of Covered Persons in activities that are prohibited under subdivision “D” of § 23 [Disciplinary Policy], *supra*;¹⁶⁷
- (ii) Performing self-evaluations, internal investigations, and audits;¹⁶⁸
- (iii) Filing a compliance complaint;
- (iv) Making compliance inquiries;
- (v) Cooperating with or implementing remedial actions in response to noted compliance deficiencies and/or failures;¹⁶⁹
- (vi) Reporting to or providing (or threatening to report or provide) information to appropriate officials as provided under Labor Law §§ 740 and 741;¹⁷⁰
- (vii) Objecting to or refusing to participate in any activity, policy or practice that:
 - (a) Violates applicable law¹⁷¹ or the System’s internal policies;
 - (c) Constitutes improper quality of patient care;¹⁷² or
 - (d) Constitutes health care fraud;¹⁷³
- (viii) Disclosing or otherwise reporting “information concerning acts of wrongdoing, misconduct, malfeasance, or other inappropriate behavior” by a Covered Person involving, for example, “investments, travel, the

¹⁶⁷ See 18 NYCRR § 521.3[c][8].

¹⁶⁸ See *id.*

¹⁶⁹ See *id.*

¹⁷⁰ See Social Services Law § 363-d [2][h]; 18 NYCRR § 521.3 [c][8]; *see also* Labor Law §§ 740[2][a-b], 741 [2][a]. Note, Attachment IX of this Policy provides an overview of Labor Law §§ 740 and 741 and other whistleblower protection laws.

¹⁷¹ See Labor Law § 740 [2][c]; *see also* 45 CFR § 160.316 [c].

¹⁷² See *id.* at § 741 [2][b].

¹⁷³ See *id.* at § 740 [2][c].

acquisition of real property and the disposition of real and personal property and the procurement of goods and services”;¹⁷⁴

- (ix) Exercising any right established, or participating in any process provided for, under HIPAA including, without limitation, the HIPAA Privacy and Breach Notification Rules;¹⁷⁵ and
- (x) “Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under” the System’s internal policies and procedures and applicable Federal or State law;¹⁷⁶

B. Whistleblower Defined

The term “Whistleblower” means any Covered Person or other individual or entity that engages in Protected Conduct as described in subdivision “A” of this section, *supra*.

C. Retaliation Defined

The term “Retaliation” (or retaliatory conduct or action) means the discharge, suspension, demotion, engagement of threatening or coercive conduct, penalization, discrimination or other adverse employment, contractual, business-related or patient care-related action imposed against any individual or entity as a consequence of any individual’s engagement in Protected Conduct or other participation in the Program.¹⁷⁷

D. Disciplinary Action for Retaliatory Conduct

Any Covered Person, or other individual or entity that is under contract, affiliation agreement or has established any other agreement with the System, that engages in retaliatory conduct against a Whistleblower shall face Disciplinary Action, up to and including termination of employment, contract, and/or other affiliation with NYC Health + Hospitals, as outlined in the Disciplinary Policy in § 23 of this OP, *supra*.

E. Applicability of Labor Law §§ 740 & 741

(i) *Overview*

Labor Law §§ 740 and 741 prohibit retaliatory action against certain Workforce Members who, among other things, disclose or threaten to disclose to a supervisor or to a public body an activity, policy or practice of

¹⁷⁴ Public Authorities Law § 2824 [1][e] (requiring board members of state or local authorities to establish policies protecting employees from reporting compliance issues).

¹⁷⁵ See 45 CFR § 164.530 [g][1].

¹⁷⁶ 45 CFR § 160.316 [b].

¹⁷⁷ See Labor Law §§ 741[1][f], 740[1][e]; see also 45 CFR § 164.530 [g][1].

the employer that:

- (a) Is in violation of a law, rule or regulation for which the violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud;¹⁷⁸ or
- (b) The workforce member, in good faith, reasonably believes constitutes improper quality of patient care.¹⁷⁹

(ii) *Additional Information Regarding Labor Law §§ 740 and 741*

For a summary review of Labor Law §§ 740 and 741, annexed hereto as Attachment IX is an *Overview of New York Labor Law §§ 740 & 741 and other Whistleblower Laws*, which provides, in pertinent part, a more detailed overview of Labor Law §§ 740 and 741 than that outlined in ¶ (i) of this subdivision.¹⁸⁰

25. **ADVERSE MANAGERIAL ACTIONS THAT AFFECT COMPLIANCE PERSONNEL OR MEMBERS OF FORMAL COMPLIANCE WORKGROUPS OR COMMITTEES**

A. Policy

A managerial (Group 11) employee whose job functions include acting as compliance officer or who is a member of one of the formal corporate compliance workgroups or committees outlined in § 11 [**Establishment of Compliance Committees**], who alleges that he/she has been subjected to an adverse managerial action based on his/her reporting of a Prohibited Act (*see* subdivision “D” of § 23, *supra*) to the OCC, Inspector General, a Corporate Officer or a facility or subsidiary Chief Executive Officer pursuant to the employee’s responsibilities, duties, and functions as a compliance officer and/or member of a formal compliance workgroup or committee, may request, in the manner outlined in subdivision “C” of this section below, an independent review of the adverse managerial action by the co-chairs of the ECW (*see* ¶ (ii) of subdivision “A”, § 11, *supra*). Where the President is serving as one of the co-Chairs of the ECW, the President may, at his or her discretion, appoint a designee from the ECW to perform such review on his/her behalf.¹⁸¹ If either of the co-chairs participated in the adverse managerial decision, the review will be conducted by a Central Office Senior Vice President who did not participate in the adverse managerial decision.¹⁸²

¹⁷⁸ N.Y. Labor Law § 740 [2][a].

¹⁷⁹ N.Y. Labor Law §741 [2][a].

¹⁸⁰ *See* ¶ (x) of subdivision “B”, § 7 [**Attachments**], *supra*.

¹⁸¹ If a designee is appointed from the ECW to perform a review, such appointee must not work at or have oversight responsibilities at the facility, unit, or entity where the affected manger worked.

¹⁸² In circumstances where it is necessary for a Central Office Senior Vice President (“SVP”) to conduct a review of

B. “Adverse Managerial Action” Defined

For purposes of this section, the term “adverse managerial action” shall mean any supervisory action that could reasonably be interpreted as negatively affecting the employment status or salary of a managerial employee including, but not limited to, demotion, dismissal, termination or removal of authority or responsibility.

C. Procedure for Request of Independent Review

- (i) A request for an independent review of an adverse managerial action made by the affected manager shall be made in writing to the OCC (at the mailing address or email address of the OCC provided in subdivision “B” of § 22 [**Mandatory Reporting and Compliance with Investigations**], *supra*) within ten (10) business days after the receipt of the adverse managerial decision.
- (ii) The affected manager should submit along with his/her request for review any documents, affidavits, or written arguments that he/she believes should be considered by the reviewer(s). The affected manager shall provide his/her contact information along with the request.
- (iii) The OCC shall contact (and document such contact) the affected manager within five (5) business days of receiving the affected manager’s request for review to acknowledge the receipt of the same. If the affected manager does not receive such acknowledgement from the OCC, the affected manager shall follow up directly with the OCC via phone as provided in subdivision “B” of § 22 [**Mandatory Reporting and Compliance with Investigations**], *supra*). Note, where the OCC was involved in the adverse managerial action, the CCO will refer the request to the other co-chair of the ECW (if both co-chairs of the ECW were involved in the adverse managerial action, then the matter will be referred to a Central Office Senior Vice President who was not involved in the adverse managerial action) for handling, processing, and determination.
- (iv) Upon receipt of a request to review an adverse managerial action, the OCC shall provide a copy of such request to the other reviewer.

D. Independent Review is Final

The reviewer(s) shall use his/her own discretion on the appropriate method for reviewing the adverse managerial decision. However, it is specifically intended that no formal hearing shall be conducted. The decision of the reviewer(s) is final

an adverse managerial action, the SVP appointed must not work at or have oversight responsibilities at the facility, unit or entity where the affected manager worked.

and is not subject to further administrative review. The affected manager will be notified in writing of the result of the review within twenty (20) workdays after the OCC's receipt of the request for review.

If the reviewer(s) disagrees with the adverse managerial decision, he/she may direct the Vice President of Human Resources to take appropriate remedial action including, but not limited to, the following actions:

- (i) Cancel the action and restore the employee to his/her previous assignment and status (retroactive to the date of the adverse decision); or
- (ii) Reassign the employee to another comparable managerial (Group 11) position; or
- (iii) Change the effective date of the adverse decision.

26. QUESTIONS REGARDING THE APPLICATION OF THIS POLICY

Any questions regarding the application or interpretation of this OP may be addressed to the OCC by phone, e-mail, facsimile, confidential compliance helpline or mail as provided hereinabove in subdivision "B" of § 22 [**Mandatory Reporting and Compliance with Investigations**].

27. APPLICABLE LAW PREVAILS

Nothing in this OP shall be construed to require or permit any act contrary to law or regulation and, in the event of a conflict between this OP and any law or regulation, the law or regulation shall control.

28. FUTURE POLICIES/DEVIATION FROM THIS POLICY¹⁸³

- A. The creation of future policies or procedures concerning the Program shall not supersede this OP unless the author of such policies and procedures has consulted with the OCC regarding the implementation of the same and such preemption:
 - (i) Is consistent with applicable law;
 - (ii) Is clear, and specifically states that such policy or procedure supersedes this OP;

¹⁸³ Note, the POPC, annexed hereto as Attachment V-a, is a standalone document and provided herein for reference purposes. The POPC can only be supplemented, altered or otherwise amended through official resolution and adoption by the NYC Health + Hospitals Board of Directors. With regard to the "Plain Language Version" of Chapter 68 of the New York City Charter (*see* Attachment VI), this document was created by the New York City Conflicts of Interest Board and may not be altered by the System.

- (iii) Is promulgated in manner that complies with all internal practices, procedures and other requirements for the establishment of System-wide policies;
 - (iv) Does not interfere with the CCO's responsibility to implement and maintain an effective System-wide compliance and ethics program; and
 - (v) Has been approved by the President and Chief Executive Officer.
- B. Notwithstanding the provisions set forth hereinabove in subdivision "A" of this section, upon consultation with the CCO, the President of MetroPlus may, in his/her administration and implementation of this OP, approve and implement supplemental internal policies, procedures, and practices that are consistent with this OP and applicable Federal and State law that govern health plans and insurance institutions as he/she deems necessary to fulfill MetroPlus' compliance obligations under applicable Federal and State law provided that paragraphs (iii) and (iv) of subdivision "A" of this section are adhered to.

29. ONGOING REVIEW OF POLICY

The CCO shall be responsible for the periodic review and, where necessary, the amendment, updating, and supplementation of this Policy to ensure that the purposes and procedures outlined herein remain consistent with applicable law and compliance program best practices. Such periodic review shall:

- A. Take place at a frequency prescribed by applicable law (including hospital accreditation requirements) but in no event less than on a biannual basis; and
- B. Be documented by the CCO.

In the event that the CCO determines that this OP requires supplementation, updating or otherwise necessitates amendment, the CCO shall ensure that such amendment satisfies the procedures and requirements set forth in subdivision "A" of § 28 [**Future Policies/Deviations from this Policy**], *supra*.

30. EFFECTIVE DATE

This OP shall become effective as of the date first written above and shall remain in effect until explicitly modified or suspended by the President of NYC Health + Hospitals.

ATTACHMENT I

**NYC HEALTH + HOSPITALS
CORPORATE COMPLIANCE AND ETHICS PROGRAM**

**SUMMARY OF WORKFORCE MEMBER,
BUSINESS PARTNER, AND AGENT RESPONSIBILITIES**



NYC HEALTH + HOSPITALS

CORPORATE COMPLIANCE AND ETHICS PROGRAM

SUMMARY OF WORKFORCE MEMBER, BUSINESS PARTNER, AND AGENT RESPONSIBILITIES

It is mandatory that all Workforce Members, Business Partners, and Agents (collectively “Covered Persons”), at each NYC Health + Hospitals (the “System”) facility, unit, and entity, comply with the requirements set forth in System Operating Procedure (“OP”) 50-1 - *Corporate Compliance and Ethics Program* (the “Program”). To satisfy these requirements, it is mandatory that all Covered Persons abide by the following compliance mandates:

- Adhere to compliance standards;
- Adhere to standards of conduct;
- Protect whistleblowers by prohibiting retaliation;
- Refrain from engaging in prohibited activities;
- Report compliance issues and concerns;
- Commit to ethical conduct; and
- Protect the privacy and security of confidential information.

Covered Persons who fail to comply with these mandates, which are described in greater detail below, shall be subject to disciplinary action up to and including termination of employment, contract or other relationship with the System.

1. Adherence to Compliance Standards.¹ The System has established an organizational culture that fosters the prevention, detection, and resolution of any form of conduct that fails to comply with applicable law or the System’s own ethical and business policies. All Covered Persons must refrain from engaging in acts that constitute fraud, waste or abuse, or any other conduct that is, or reasonably likely to be, contrary to this organizational culture.

2. Commitment to Ethical Conduct. All Covered Persons are expected to carry out their System functions and duties in an ethical manner. In a nutshell, ethics is *doing the right thing*. Examples of ethical conduct include: acting fairly and honestly; complying with standards of conduct and applicable legal requirements; following industry practices that are lawful, fair, and non-deceptive; reporting compliance violations; and enforcing disciplinary policies.

3. Protecting the Privacy and Security of Confidential Information. All Covered Persons are responsible for protecting the confidentiality, privacy, and security of confidential System information. Covered Persons shall not access, disclose, transmit, or otherwise use confidential System information in a manner that is inconsistent with applicable law or the System’s internal information governance policies or contractual requirements (e.g., business associate, qualified service organization agreements, and other contractual provisions that govern the use of confidential information). Confidential information includes: (i) patient protected health information; (ii) the personally identifiable information and/or private information of Covered Persons; and (iii) System business information that is protected under a legal privilege or applicable law, or is otherwise not subject to public disclosure.

4. Adherence to Standards of Conduct. All Covered Persons must adhere to the various Standards of Conduct promulgated by the System or enacted by law that apply to their function, role, and/or association with the System.² Some of the key Standards of Conduct are provided below:

➤ **Principles of Professional Conduct (“POPC”)** - All Covered Persons are required to adhere to the System’s POPC – a guide that sets forth the System’s compliance expectations and commitment to obey all applicable Federal and State laws. The POPC also describes the System’s standards of professional conduct and efforts to prevent fraud, waste, and abuse.

¹ As used in this summary, the term “applicable law” includes all applicable Federal, New York State, and local laws.

² The POPC, Chapter 68, and the Code of Ethics, as well as additional System standards of conduct (e.g., standards of conduct concerning pharmaceutical company gifts and sponsored educational programs (OP 20-55), nepotism (OP 20-54), and social media (OP 20-61)) may be accessed on the System’s public website at: <http://www.nychealthandhospitals.org/policies-procedures/>.

➤ Chapter 68 of the NYC Charter (“Chapter 68”) - All System employees and Members of the System’s Board of Directors (including the Board’s designee agents and all Directors of the System’s wholly owned subsidiaries) must adhere to *Chapter 68 of the New York City Charter*, which governs the interaction between the private interests of employees and Board members and their official System duties.

➤ Code of Ethics - The System’s Code of Ethics is binding on all System affiliate (e.g., SUNY Downstate, PAGNY, Mount Sinai, and NYU) personnel who perform System functions, duties, and services under an affiliation agreement with the System. Members of the System’s various Community Advisory Boards and Auxiliaries and other System personnel not covered by Chapter 68 must also adhere to the Code of Ethics. The Code of Ethics governs the relationship between the private interests and official System duties of these individuals.

5. Mandatory Reporting. All Covered Persons have an affirmative obligation to report to the Office of Corporate Compliance (“OCC”) the commission of (or attempt or plan to commit) any activity prohibited under OP 50-1 of which they become aware. Reports shall be made to:

**NYC Health + Hospitals
Office of Corporate Compliance
160 Water Street, Suite 1129, New York, NY 10038
Telephone: (646) 458-7799; Facsimile: (646) 458-5624
E-mail: COMPLIANCE@nychhc.org**

Confidential Compliance Helpline: 1-866-HELP-HHC (1-866-435-7442)

OneCity Health DSRIP Compliance Helpline: 1-844-805-0105 (For DSRIP-related compliance issues)

MetroPlus Health Plan Compliance Hotline: 1-888-245-7247 (For MetroPlus compliance issues)

6. Prohibition of Retaliation / Whistleblower Protection. The System is committed to protecting whistleblowers. As such, the System strictly prohibits intimidation or retaliation, in any form, against any Covered Person who in good faith participates in the Program through any of the following protected conduct: (i) reporting and investigating potential compliance issues; (ii) performing self-evaluations, internal investigations, and audits; (iii) filing compliance complaints; (iv) making compliance inquiries; (v) cooperating with or implementing remedial actions in response to compliance deficiencies; (vi) providing information to appropriate officials as provided under NYS Labor Law §§ 740 and 741; or (vii) objecting to any activity that constitutes healthcare fraud, improper quality of care, or a violation of System policy or applicable law.

“Retaliation” refers to the discharge, suspension, demotion, penalization, discrimination or other adverse employment, contractual, business-related or patient care-related action imposed against any individual or entity as a consequence of their engagement in protected conduct or other participation in the Program.

7. Prohibited Activities. Covered Persons are prohibited from engaging in any of the following activities:

- Participating in the Program in a non-compliant manner by failing to abide by any of the compliance mandates listed in sections one through six above;
- Participating in the Program in a non-compliant manner by violating OP 50-1 or related compliance policies;
- Failing to cooperate with internal or external audits or investigations;
- Failing to report a matter to government officials or regulatory oversight agencies when required by applicable law or internal System policy;
- Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior; or
- Failing to comply with Federal healthcare program and private payor requirements.

Note: This document is a summary guide and does not replace the specific language of OP 50-1. Please contact the OCC (see section 5 above) if you have any questions regarding this document, OP 50-1, or any compliance issue or concern. The full text of OP-50-1, the System’s standards of conduct, and related compliance policies may be accessed on the System’s public website at: <http://www.nychealthandhospitals.org/policies-procedures/>.

ATTACHMENT II

**AN OVERVIEW OF OPERATING PROCEDURE (“OP”) 50-1-
NYC HEALTH + HOSPITALS
CORPORATE COMPLIANCE AND ETHICS PROGRAM**

**A ROADMAP TO ASSIST WORKFORCE MEMBERS, BUSINESS
PARTNERS, AND AGENTS TO UNDERSTAND THEIR
RESPONSIBILITIES AND OBLIGATIONS UNDER OP 50-1**



An Overview of Operating Procedure (“OP”) 50-1 –
NYC Health + Hospitals
Corporate Compliance and Ethics Program

**A Roadmap to Assist Workforce Members, Business Partners, and Agents
to understand their Responsibilities and Obligations under OP 50-1**

Wayne A. McNulty
Senior Assistant Vice President &
Chief Corporate Compliance Officer
Office of Corporate Compliance

January 4, 2018



- This PowerPoint presentation (“Presentation”) serves as a roadmap and summary of the pertinent provisions of NYC Health + Hospitals Operating Procedure 50-1 (“OP 50-1”) - *Corporate Compliance and Ethics Program* (the “Program”)
- This Presentation is not intended to replace OP 50-1. Rather, this Presentation should be read in conjunction with OP 50-1 and other compliance-related policies and procedures promulgated by NYC Health + Hospitals (the “System”). Workforce Members, Business Partners, and Agents (hereinafter collectively “Covered Persons”) are responsible for becoming familiar with OP 50-1 and complying with the same.

This Presentation will cover the following key points and topics:

- ❖ What is the focus and purpose of OP 50-1?
- ❖ As used in OP 50-1, what do the terms “compliance” and “ethics” mean?
- ❖ What is the applicability and scope of OP 50-1 (*i.e.*, who is covered under OP 50-1)?
- ❖ What are the eight (8) elements of an effective compliance program?
- ❖ What are the responsibilities of Covered Persons under OP 50-1?
- ❖ What are the obligations of Covered Persons with regard to confidential information?
- ❖ How should Covered Persons or other individuals or entities report a compliance issue, concern, violation or other compliance matter, or seek guidance related to a potential or actual compliance matter?
- ❖ What is the System’s disciplinary policy for those Covered Persons who or that commit a Prohibited Act or otherwise fail to comply with OP 50-1?
- ❖ What protections from retaliation are afforded to Covered Persons and other individuals or entities who raise compliance concerns?

- OP 50-1:
 - ❑ Governs how the NYC Health + Hospitals Corporate Compliance and Ethics Program is to be implemented, managed, enforced, monitored, and otherwise operated; and
 - ❑ Outlines the roles and responsibilities of, as well as the procedures that must be followed by, each Covered Person to meet their obligation to affirmatively participate in the Program. (OP 50-1 § 1 (A)).

Note:

- The terms “Compliance” and “Ethics” are defined below in slide 7 of this Presentation; and
- Examples of Covered Persons are provided below in slides 10-14 of this Presentation.



Overview of OP 50-1 (cont.) (2 of 5) – What is the Focus of the Program?

- The Program is focused on the prevention, detection, and correction of any departure from the System’s legal, regulatory, professional, fiduciary, and ethical obligations as they relate to the following:
- ❑ Fraud, waste, and abuse;
 - ❑ Federal healthcare program conditions of participation, as well as private payor requirements;
 - ❑ Information governance;
 - ❑ Risk identification, assessment and prioritization;
 - ❑ Corporate governance; and
 - ❑ The establishment and monitoring of effective internal controls.

Note: The terms “Fraud”, “Waste”, and “Abuse” are defined in slide 8 of this Presentation.

- The purpose of the Program is to:
 - ❑ Proactively identify and address System-wide compliance issues and concerns; and
 - ❑ Exercise due diligence to deter fraud, waste and abuse, as well as unprofessional and criminal conduct.

- What is *Compliance*?
 - **COMPLIANCE** is an organizational culture that fosters the prevention, detection, and resolution of conduct that fails to comply with applicable law and/or an organization's own ethical and business policies.

- What is *Ethics*?
 - **ETHICS** in a nutshell is doing the right thing. All Covered Persons are expected to carryout their functions, duties, responsibilities, and obligations in an ethical and legal manner.

 - **Examples of ethical conduct include:** (i) acting fairly and honestly; (ii) complying with standards of conduct that articulate an organization's commitment to comply with applicable law and outline its ethical requirements of compliance; (iii) complying with all applicable legal requirements including, without limitation, fraud, waste, and abuse laws; (iv) following applicable industry practices that are lawful, fair, and non-deceptive in nature; (v) adherence by professionals to applicable ethical standards of conduct dictated by their respective professional organizations; (vi) reporting compliance violations (“Compliance Reporting”); and (vii) enforcing disciplinary policies ((OP 50-1 § 2-a(A-B)).

Overview of OP 50-1 (cont.) (5 of 5) – *Defining the terms Fraud, Waste and Abuse*

➤ What is *Fraud*?

- ❑ **FRAUD** is an intentional deception or misrepresentation made by an individual or entity with the knowledge that the misrepresentation/deception could result in some unauthorized benefit to such individual or entity or someone else.

➤ What is *Waste*?

- ❑ **WASTE** is the overuse of services or other practices that, directly or indirectly, results in unnecessary costs to a Federal healthcare program (e.g. Medicare, Medicaid, and Tricare).
- ❑ Generally, waste is not the result of criminally negligent actions, but rather an end product of the misuse of resources.

➤ What is *Abuse*?

- ❑ **ABUSE** is any action that may directly or indirectly result in an unnecessary cost to a Federal healthcare program and involves payments for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.



- OP 50-1 applies to all **Covered Persons** at each NYC Health + Hospitals *facility, unit, and entity including, but not limited to:*
 - All acute care facilities and associated extension clinics;
 - All diagnostic and treatment centers (“D&TCs”) (including all D&TCs designated as Federally Qualified Healthcare Centers “FQHC”) and associated extension clinics;
 - All long-term acute care facilities and nursing homes;
 - NYC Health + Hospitals/At Home; and
 - All subsidiary corporations.

- **Covered Persons** fall into one or more of the following three categories:
- ❑ **CATEGORY # 1** - Workforce Members;
 - ❑ **CATEGORY # 2** - Business Partners; and
 - ❑ **CATEGORY # 3** - Agents

➤ **A Workforce Member** is any of the following System individuals, whether serving in a temporary or permanent capacity on the System’s premises or remotely, who perform System duties, functions or activities on a full-time, part-time, or *per diem* basis:

- **Employees;**
- **Executives;**
- **Members of the medical staff;**
- **Members of the NYC Health + Hospitals Board of Directors and their designee agents;**
- **Directors of all wholly owned System subsidiaries;**
- **Trainees;**
- **Any individual whose conduct, in the performance of work functions and duties on behalf of the System, is under the direct control of the System, whether or not they are paid by the System;**
- **Affiliate employees and other affiliate personnel;**
- **Interns;**
- **Personnel;**
- **Members of the Gotham Health FQHC, Inc., Board of Directors;**
- **Appointees;**
- **Students; and**
- **Volunteers.**



Applicability and Scope of OP 50-1 (cont.) (4 of 6) – Category II - What is a Business Partner?

- A business partner is any non-Workforce Member contractor, subcontractor, vendor or other third-party (collectively “Third Party”) who is required by law or contract to comply with OP 50-1 including, without limitation, the following Third Parties:
 - ❑ Any Third Party that, acting on behalf of or otherwise being associated with NYC Health + Hospitals, engages in activities, functions, and duties that:
 - Contribute to the System’s entitlement to receive payment from Federal healthcare programs or private payors; or
 - May place the System in a position to commit significant noncompliance with Federal health care program or private payor requirements or fraud, waste and abuse prohibitions.
 - ❑ OneCity Health Delivery System Reform Incentive Payment (“DSRIP”) Program Performing System Partners.

Applicability and Scope of OP 50-1 (cont.) (5 of 6) – Category II – Examples of *Business Partners*?

- The following are some examples of Third Parties that are considered Business Partners:
 - ❑ Third Parties that deliver, furnish, prescribe, direct, order or otherwise provide healthcare items and/or services;
 - ❑ Third parties that provide billing or coding functions;
 - ❑ Third Parties that establish and administer the formulary of the System;
 - ❑ Third Parties that establish and administer medical benefit coverage policies and procedures;
 - ❑ Third Parties that review beneficiary claims and services submitted for payment to Federal healthcare programs or private payors; and
 - ❑ Third Parties that exercise decision making authority (*e.g.*, clinical decisions, coverage determinations, appeals and grievances, health plan enrollment/disenrollment functions, the processing of pharmacy or medical claims) in the administration of Federal healthcare programs and private payor health plans.

- An Agent is an individual or entity that has entered into an agency relationship with the System.
- An Agent may fall into the category of Workforce Member or Business Partner.

(OP 50-1 § 6(C)).



- In order for the System to maintain an effective compliance program, the following **eight (8) basic elements** must be satisfied:
- ❑ **ELEMENT # 1** – The promulgation of written policies and procedures that outline: (i) compliance expectations as embodied in a code of conduct; (ii) how the Program is implemented; (iii) how Covered Persons can report and resolve compliance concerns; and (iv) how reported compliance concerns are investigated and resolved;
 - ❑ **ELEMENT # 2** - The appointment of a corporate compliance officer responsible for the Program’s day-to-day operation;
 - ❑ **ELEMENT # 3** – The provision of training and education for all Covered Persons;
 - ❑ **ELEMENT # 4** – The establishment of communication lines to the responsible compliance person that are accessible to all Covered Persons and allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of compliance issues;

- **The eight (8) basic elements of an effective compliance program (cont.) (Elements 5-8):**
- ❑ **ELEMENT # 5** – The establishment of disciplinary policies to encourage good faith participation in the Program, including policies that articulate expectations for compliance reporting and outline sanctions for failing to report suspected problems, participating in non-compliant behavior or encouraging, directing, facilitating or permitting non-compliant behavior;
 - ❑ **ELEMENT # 6** – The creation of a process to routinely identify compliance risk areas;
 - ❑ **ELEMENT # 7** – The implementation of a system to address compliance concerns that come to the attention of the Office of Corporate Compliance (“OCC”);
 - ❑ **ELEMENT # 8** – The establishment of a whistleblower protection policy.



- The eight (8) basic elements are coordinated with a focus to implement oversight activities covering, at the minimum, the following key compliance risk areas:
- Billing and claims submission;
 - Payments and claims reimbursement;
 - Mandatory reporting, including overpayments;
 - Medical necessity and quality of care;
 - Credentialing;
 - Corporate governance; and
 - Any other risk area that is identified, or should with due diligence be identified, by the System.

- In addition to the basic eight elements and required risk areas, the System must also satisfy all applicable Federal and State laws and other legal obligations that govern the System’s compliance program responsibilities and oversight activities including, without limitation, compliance requirements applicable to:
- Nursing homes and long-term care acute facilities;
 - Accountable care organizations;
 - FQHCs;
 - The New York State Department of Health (“SDOH”) DSRIP Program;
 - World Trade Center Health Program;
 - Medicare Advantage Organizations and their first tier, downstream, and related entities, as applicable; and
 - Health plans.

What are some of the Responsibilities of Covered Persons under OP 50-1 (1 of 5) – General Responsibilities

- Under OP 50-1, Covered Persons are required to affirmatively participate in the Program, which includes, for example, the following:
 - Conducting themselves in a manner that is ethical, legal, and consistent with the System's culture of compliance;
 - Compliance with OP 50-1, as well as all applicable Federal and State laws, rules, and regulations;
 - Cooperating with internal investigations;
 - Reporting compliance concerns;
 - Refraining from engaging in any Prohibited Acts;
 - Refraining from engaging in any retaliatory conduct; and
 - Adhering to the System's standards of conduct.

(OP 50-1 § 12 (A)).

What are some of the Responsibilities of Covered Persons under OP 50-1 (cont.) (2 of 5) – Adhering to the System’s Standards of Conduct

- With regard to System’s standards of conduct, all Covered Persons must comply with the following, as applicable:
- ❑ **NYC Health + Hospitals Principles of Professional Conduct (“POPC”)** - All Covered Persons are required to adhere to the *POPC*.
 - The *POPC* is a guide that sets forth the System’s compliance expectations and commitment to comply with all applicable Federal and State laws.
 - The *POPC* also describes the System’s standards of professional conduct (*i.e.*, code of conduct) and efforts to prevent fraud, waste, and abuse. The *POPC* is annexed to OP 50-1 along with the *NYC Health + Hospitals Principles of Professional Conduct Frequently Ask Questions (“POPC FAQs”)*. (*See Attachments V-a & V-b of OP 50-1*).
 - All Covered Persons are required to read, be familiar with and comply with the *POPC*. Additionally, Covered Persons are urged to review the *POPC FAQs* to better understand some of the requirements of the *POPC*.
 - ❑ **Chapter 68** - All System employees and Members of the NYC Health + Hospitals Board of Directors and Directors of the System’s wholly-owned subsidiaries are required to adhere to the Conflicts of Interest Law found under Chapter 68 of the New York City Charter.

What are some of the Responsibilities of Covered Persons under OP 50-1 (cont.) (3 of 5) – Adhering to the System’s Standards of Conduct (cont.)

- **Code of Ethics** - All System affiliate (*e.g.*, S.U.N.Y. Downstate, PAGNY, Mount Sinai, NYU) employees and other affiliate personnel, who perform System functions, duties, and services pursuant to an affiliation agreement with the System, are required to adhere to the *NYC Health + Hospitals Code of Ethics* (the “Code of Ethics”). Additionally, the *Code of Ethics* applies to all Member’s of the System’s Community Advisory Boards and Auxiliaries and other personnel who are not covered under Chapter 68.

- **OP 20-55** - All System employees are required to adhere to OP 20-55 (*Pharmaceutical Company Gifts and Sponsored Educational Programs*), which sets forth the obligations of these individuals as they relate to gifts from pharmaceutical and other companies that provide or intend to provide supplies and/or equipment to the System.
 - By way of the System’s *POPC*, as well as the obligations set forth under the Chapter 68, all members of the System’s Board of Directors and Directors of the System’s wholly owned subsidiaries who are not directly covered under OP 20-55 are subject to the same restrictions outlined in OP 20-55.

 - By way of the System’s *By-laws* and *Code of Ethics*, all affiliate employees, members of the System’s Community Advisory Board and Auxiliary, and other System personnel who are not directly covered under OP 20-55, are subject to the same restrictions outlined in OP 20-55.

What are some of the Responsibilities of Covered Persons under OP 50-1 (cont.) (4 of 5) – Adhering to the System’s Standards of Conduct (cont.)

- **OP 20-54** - All Covered Persons shall comply with OP 20-54 (*Nepotism*), which, with regard to Covered Persons who serve in a supervisory role or capacity at the System, sets forth the restrictions that Covered Persons are subject to as they relate to the supervision of relatives. OP 20-54 also prohibits two or more relatives who work in the same facility from working in the same unit regardless of whether a supervisory relationship exists

- **OP 20-61** - All Workforce Members shall comply with OP 20-61 *Social Media Use*, which serves as a guide to help Workforce Members: (i) appropriately use social media; and (iii) identify and avoid potential issues related to the use of social media.

What are some of the Responsibilities of Covered Persons under OP 50-1 (cont.) (5 of 5) – Protecting the Privacy and Security of Confidential Information

- All Covered Persons are responsible for protecting the confidentiality, privacy, and security of confidential System information.
- Covered Persons shall not access, disclose, transmit, or otherwise use confidential System information in a manner that is inconsistent with applicable law or the System’s internal information governance policies or contractual requirements (e.g. business associate agreements, qualified service organizational agreements, and other contractual provisions that govern the use of confidential information).
- Confidential information includes:
 - ❑ Patient protected health information;
 - ❑ The personally identifiable information and/or private information of Covered Persons; and
 - ❑ System business information that is protected under a legal privilege or applicable law, or is otherwise not subject to public disclosure.
- In addition, all Workforce Members must adhere to the following System policies:
 - ❑ Record Management Program set forth in OP 120-19 (*Corporate Record Management Program and Guidelines for Corporate Record Retention and Disposal*);
 - ❑ HIPAA Privacy Program and Security Program and related patient confidentiality policies and procedures in the 240 and 250 Series, respectively, of the System’s Operating Procedures; and
 - ❑ The security policies found on the NYC Health + Hospitals Enterprise Information Technology Services security homepage, including but not limited to, policies that govern asset management, access control, and security incident response.



Mandatory Reporting Requirements under OP 50-1

- **MANDATORY REPORTING** - NYC Health + Hospitals places an affirmative responsibility and obligation on all Covered Persons to report to the OCC the commission of (or attempt or plan to commit) any Prohibited Act under OP 50-1 of which they become aware via: (i) the NYC Health + Hospitals Compliance Helpline; (ii) through the OCC website, telephone, fax or email; or (iii) by letter as follows:

NYC Health + Hospitals
Office of Corporate Compliance
160 Water Street, Suite 1129

New York, NY 10038

Telephone: (646) 458-7799

Facsimile: (646) 458-5624

E-mail: COMPLIANCE@nychhc.org

Confidential Compliance Helpline:

1-866-HELP-HHC (1-866-435-7442)

DSRIP Compliance Helpline (for DSRIP-related compliance issues): 1-844-805-0105

MetroPlus Health Plan Compliance Hotline (for MetroPlus compliance issues): 1-888-245-7247

- **SANCTIONS FOR NONCOMPLIANCE**: Failure to report a known 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 up to and including termination of employment, contract, other affiliation with the System. In addition, any Covered Person that attempts to interfere with or influence the outcome of a compliance investigation shall be subject to disciplinary action.

The Disciplinary Policy under OP 50-1 (1 of 2) – What Acts are Prohibited under the Program?

- All Covered Persons shall be subject to disciplinary action up to and including termination of employment, contract or other affiliation with the System for failing to comply with and to affirmatively participate in the Program or engaging in conduct that otherwise constitutes wrongdoing (collectively “Prohibited Acts”). Some examples of Prohibited Acts include the following:
- ✓ Failing to conduct themselves in a legally compliant and ethical manner;
 - ✓ Participating in the Program in a non-compliant manner by failing to comply with any of the requirements of OP 50-1, or by violating OP 50-1 or related compliance policies;
 - ✓ Failing to cooperate with internal or external audits or investigations;
 - ✓ Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;
 - ✓ Failing to comply with the POPC;
 - ✓ Failing to comply with applicable Federal and State laws and/or Federal healthcare program and private payor requirements;
 - ✓ Refusing to cooperate with government investigators or other regulatory enforcement bodies; and
 - ✓ Engaging in retaliation against a person who reports actual or suspected Program violations.

- Examples of Disciplinary Action that a Covered Person may face for engaging in a Prohibited Act include, but are not limited to, the following:
 - ✓ Education, retraining or corrective coaching;
 - ✓ Oral or written warnings regarding the Prohibited Act;
 - ✓ Counseling;
 - ✓ Financial Penalties;
 - ✓ Demotion in grade or title;
 - ✓ Suspension without pay;
 - ✓ The revocation of privileges as provided under the applicable facility Medical Staff By-laws; and
 - ✓ Termination of employment, contract or other affiliation with the System.

- Retaliation is any of the following actions that arise as a result of an individual or entity that reports potential compliance issues and other concerns, performs self-evaluations and audits regarding System operations and other activities, files a compliance complaint, or otherwise engages in the affirmative participation in the Program:
 - ✓ The discharge, demotion, suspension, harassment, exposure to threatening behavior, adverse employment action or any other form of discrimination against the terms and conditions of employment, or the imposition of penalties or harm;
 - ✓ The discharge, suspension, harassment, revocation, exposure to threatening behavior, adverse contractual or business-related action or any other form of discrimination against the terms and conditions of an individual or entity's contract and/or business relationship with the System;
 - ✓ The imposition of penalties or harm, as to an individual or entity; or
 - ✓ The denial, alteration or any other untoward affect related to the provision of patient care services.

- NYC Health + Hospitals strictly prohibits intimidation or retaliation, in any form, against any Covered Person or other individual or entity that, in good faith, participates in the Program by engaging in compliance-related conduct or other similar activities.

- Any Covered Person or other individual or entity that is under contract, affiliation or has established any other agreement with the System, that engages in retaliatory action against a whistleblower, shall face disciplinary action up to and including termination of employment, contract, and/or other affiliation with NYC Health + Hospitals.

(OP 50-1 § 24 (A), (C) & (D)).



➤ **Contact the OCC at your facility or program**

☐ **Manhattan Facilities**

(212) 562-6570 – Bellevue
(212) 939-2414 – Harlem
(212) 423-8936 – Metropolitan

☐ **Queens Facilities**

(718) 883-2019 – Queens
(718) 334-2502 – Elmhurst

☐ **Bronx Facilities**

(718) 918-3457 – Jacobi
(718) 519-2345 – North Central Bronx
(718) 579-4639 – Lincoln

☐ **Brooklyn Facilities**

(718) 245-1095 – Kings County
(718) 963-8920 – Woodhull
(718) 616-4924 – Coney Island

☐ **All Long-term Care Facilities**

(718) 245-7278

☐ **NYC Health + Hospitals/At Home**

(646) 458-5695

☐ **HHC ACO, FQHC, DSRIP and WTC Health Program**

(646) 458-5632

➤ **Contact the OCC at Central Office**

☐ **Compliance Helpline**

1-866 – HELP – HHC (1 – 866 – 435 – 7442)

Confidential – Anonymous

24 Hours a Day – 7 Days a Week

DSRIP Compliance Helpline (for DSRIP-related compliance issues): **1-844-805-0105**

MetroPlus Health Plan Compliance Hotline (for MetroPlus Compliance issues): 1-888-245-7247

☐ **OCC Intranet Website**

<http://compliance.nychhc.org>

☐ **Chief Corporate Compliance Officer**

Wayne A. McNulty

Senior Assistant Vice President &
Chief Corporate Compliance Officer

Office of Corporate Compliance

160 Water Street, Suite 1129

New York, NY 10038

Telephone: (646) 458-7799

Facsimile: (646) 458-5624

E-mail: COMPLIANCE@nychhc.org

**The OCC – Always There For You –
24 Hours/Day – 7 Days/Week**

ATTACHMENT III

**OPERATING PROCEDURE 50-1 -
CORPORATE COMPLIANCE AND ETHICS PROGRAM**

UNDERSTANDING THE TERMS FRAUD, WASTE, AND ABUSE



OPERATING PROCEDURE 50-1 – CORPORATE COMPLIANCE AND ETHICS PROGRAM

UNDERSTANDING THE TERMS FRAUD, WASTE, AND ABUSE

One of the key focuses of the NYC Health + Hospitals Corporate Compliance and Ethics Program is to prevent and detect fraud, waste and abuse. The terms fraud, waste, and abuse may have various technical definitions under various laws and regulations. If you have any questions or concerns related to the meaning of these terms, please contact OCC. As an example, under the footnoted authorities, these terms are defined as follows:

TERM	DEFINITION	EXAMPLES
FRAUD	<p>Fraud is an intentional deception or misrepresentation made with the knowledge that the deception/misrepresentation could result in some unauthorized benefit to the individual or entity making such deception/misrepresentation or someone else.¹</p> <p>Fraud includes, among other things, intentionally submitting false information to the Government or a Government contractor for the purpose of obtaining money or another unauthorized benefit.²</p>	<ul style="list-style-type: none"> • Knowingly billing for services or supplies that were not provided or non-existent prescriptions; • Knowingly altering (or falsifying) claim forms or medical records to receive a higher payment; and • Knowingly soliciting, receiving, offering and/or paying for referrals to a Federal health care program.³
WASTE	<p>Waste includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to a Federal healthcare program (e.g., Medicare, Medicaid, and Tricare).⁴</p> <p>Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.⁵</p>	<ul style="list-style-type: none"> • Prescribing more medications than necessary for the treatment of a specific condition; • Ordering excessive laboratory tests; and • Conducting excessive office visits or writing excessive prescriptions.⁶
ABUSE	<p>Abuse means practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care.⁷</p> <p>Abuse is conduct or other actions that may directly or indirectly result in an unnecessary cost to a Federal health care program. Abuse involves payments for items or services when: (i) there is no legal entitlement to that payment; and (ii) the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.⁸</p>	<ul style="list-style-type: none"> • Charging excessively for services and supplies; • Upcoding or unbundling codes on a claim or other similar inappropriate coding; and • Billing for brand name drugs when generic drugs are dispensed.⁹

¹ 18 NYCRR § 515.1 (b)(7); 42 CFR § 455.2 (providing that Fraud includes any act that constitutes fraud under applicable Federal or State law).

² CMS Combatting Medicare Parts C & D Fraud, Waste and Abuse General Compliance Training Web-Based Training Course (“CMS Training”), rev. 1/17, Lesson 1, Page 2 (“L1P2”), pg. 13, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf>.

³ CMS Training, L1P4, p.15; CMS Medicare Fraud & Abuse: Prevention, Detection, And Reporting (“CMS Booklet”), (ICN 006827 September 2017), p. 3, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud_and_Abuse.pdf; see also OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8990 (Feb. 23, 1998).

⁴ CMS Training at L1P3, pg. 14.

⁵ *Id.*

⁶ *Id.* at L1P4, pg. 15.

⁷ 18 NYCRR § 515.1(b)(1); 42 CFR § 455.2.

⁸ CMS Training at L1P3, pg. 14.

⁹ *Id.* at L1P4, p.15.

ATTACHMENT IV

SUMMARY OF ELEMENTS

FOR AN EFFECTIVE COMPLIANCE AND ETHICS PROGRAM¹

¹ This Attachment IV provides a summary of the elements for an effective compliance and ethics program. The elements are a set of suggested guidelines for an effective compliance program. The summary has been compiled including elements from the Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities, Compliance and Ethics Program (42 CFR § 483.85); OIG Compliance Program Guidance for Hospitals (1998 and 2005), New York Social Services Law 363-d, U.S. Sentencing Commission Guidelines Manual (2016); the Delivery System Reform Incentive Payment (DSRIP) Program Compliance Guidance, *Revised Special Considerations for Performing Provider System (PPS) Leads' Compliance Programs* 2015; and the Medicare Managed Care Manual (2013). The elements included in the summary shall be reasonably designed, implemented, and enforced so that the program is generally effective and in preventing and detecting noncompliant conduct. The elements for an Accountable Care Organizations are referenced in Exhibit I. Finally, a summary of the compliance requirements for Federally Qualified Health Centers (“FQHC”) as found in the Health Resources and Services Administration (“HRSA”) Health Center Program – *Health Center Program Compliance Manual* is provided in Exhibit II.

Element 1 – Written Policies and Procedures	
Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities: Compliance and ethics program - 42 CFR § 483.85	Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the [Social Security] Act and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization’s entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers’ expected roles. [42 CFR § 483.85(c)(1)]
Publication of the OIG Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987 (Feb. 23, 1998)); Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858 (Jan. 31, 2005))	The development and distribution of written standards of conduct, as well as written policies and procedures that promote the hospital’s commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals. [63 Fed Reg. 8987, 8989 [1998]; 70 Fed. Reg. 4858, 4875 [2005]]
New York Social Services Law § 363-d	Written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved. [SSL § 363-d(2)(a)]
U.S. Sentencing Commission Guidelines Manual 2016	The organization shall establish standards and procedures to prevent and detect criminal conduct. [8B2.1(b)(1)] Standards and procedures means standards of conduct and internal controls that are reasonably capable of reducing the likelihood of criminal conduct. [8B2.1(b)(1) Commentary at 536]
DSRIP Compliance Program Elements	PPS Leads must have policies and procedures that describe compliance expectations specifically related to the compliance issues involving DSRIP funds. ² [OMIG DSRIP Compliance Guidance at 2]
Medicare Managed Care Manual (2013)	Sponsors must have written policies, procedures and standards of conduct that – 1. Articulate the sponsor’s commitment to comply with all applicable Federal and State standards. [Chapter 21-Rev. 109, 50.1.]
Element 2 – Designated Compliance Personnel	
Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care	Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization’s compliance and ethics

² Delivery System Reform Incentive Payment (DSRIP) Program Compliance Guidance 2015-01 - Revised Special Considerations for Performing Provider System (PPS) Leads’ Compliance Programs, (“OMIG DSRIP Compliance Guidance”), available at: https://omig.ny.gov/images/stories/compliance_alerts/20150901_DSRIP_CompGuidance_2015-01_Rev.pdf

<p>Facilities: Compliance and ethics program - 42 CFR § 483.85</p>	<p>program’s standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization. [42 CFR § 483.85(c)(2)]; and a designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer. [42 CFR § 483.85(d)]</p>
<p>Publication of the OIG Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987 (Feb. 23, 1998)); Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858 (Jan. 31, 2005))</p>	<p>The designation of a chief compliance officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body. [63 Fed Reg. 8987, 8989 [1998]; 70 Fed. Reg. 4858, 4874-4875 [2005]]</p>
<p>New York Social Services Law § 363-d</p>	<p>Designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator and shall periodically report directly to the governing body on the activities of the compliance program. [SSL § 363-d(2)(b)]</p>
<p>U.S. Sentencing Commission Guidelines Manual 2016</p>	<p>(A) The organization’s governing authority shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program.</p> <p>(B) High-level personnel of the organization shall ensure that the organization has an effective compliance and ethics program, as described in this guideline. Specific individual(s) within high-level personnel shall be assigned overall responsibility for the compliance and ethics program.</p> <p>(C) Specific individual(s) within the organization shall be delegated day-to-day operational responsibility for the compliance and ethics program. Individual(s) with operational responsibility shall report periodically to high-level personnel and, as appropriate, to the governing authority, or an appropriate subgroup of the governing authority, on the effectiveness of the compliance and ethics program. To carry out such operational responsibility, such individual(s) shall be given adequate resources, appropriate authority, and direct access to the governing authority or an appropriate subgroup of the governing authority. [8B2.1(b)(2)]</p>
<p>DSRIP Compliance Program Elements</p>	<p>The Compliance Officer must be an employee of the PPS Lead. The Compliance Officer must report directly to the PPS Lead’s chief executive or other senior administrator and shall periodically report directly to the PPS Lead on activities of the compliance program. [OMIG DSRIP Compliance Guidance at 2]</p>
<p>Medicare Managed Care Manual (2013)</p>	<p>The sponsor must designate a compliance officer and a compliance committee who report directly and are accountable to the sponsor’s chief executive or other senior management. (1) The compliance officer, vested with the day-to-day operations of the compliance program, must be an employee of the sponsor, parent organization or corporate affiliate. The compliance officer may not be an employee of an FDR. (2) The</p>

	compliance officer and the compliance committee must periodically report directly to the sponsor’s governing body on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program. (3) The sponsor’s governing body must be knowledgeable about the content and operation of the compliance program and must exercise reasonable oversight with respect to the implementation and effectiveness of the compliance program. [Chapter 21-Rev. 109, 50.2; Additional requirements for Compliance Officer found at § 50.2.1]
Element 3 - Training and Education	
Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities: Compliance and ethics program - 42 CFR § 483.85	The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at § 483.95(f) (see element #1 for additional detail) or orientation programs, or disseminating information that explains in a practical manner what is required under the program. [42 CFR § 483.85(c)(5)]
Publication of the OIG Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987 (Feb. 23, 1998)); Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858 (Jan. 31, 2005))	The development and implementation of regular, effective education and training programs for all affected employees. [63 Fed Reg. 8987, 8989 [1998]; 70 Fed. Reg. 4858, 4875 [2005]]
New York Social Services Law § 363-d	Training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member. [SSL § 363-d(2)(c)]
U.S. Sentencing Commission Guidelines Manual 2016	(A) The organization shall take reasonable steps to communicate periodically and in a practical manner its standards and procedures, and other aspects of the compliance and ethics program, to the individuals referred to in subparagraph (B) by conducting effective training programs and otherwise disseminating information appropriate to such individuals’ respective roles and responsibilities. (B) The individuals referred to in subparagraph (A) are the members of the governing authority, high-level personnel, substantial authority personnel, the organization’s employees, and, as appropriate, the organization’s agents. [8B2.1 (b)(4)(A)(B)]
DSRIP Compliance Program Elements	The PPS Lead is responsible for training and education of all affected employees, persons associated with the provider (i.e., PPS Lead), its executives and its governing body members on compliance issues and expectations. “Persons associated with the provider” include performing providers within the PPS network who are or may be eligible to receive DSRIP funds. [OMIG DSRIP Compliance Guidance at 2]
Medicare Managed Care Manual (2013)	The sponsor must establish, implement and provide effective training and education for its employees, including the CEO, senior administrators or managers, and for the governing body members, and FDRs. The training and education must occur at least annually and be made a part of the orientation for new employees,

	<p>including the chief executive and senior administrators or managers, governing body members, and FDRs. FDRs who have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse.</p> <p>Effectiveness of training, education, compliance policies and procedures, and Standards of Conduct will be apparent through sponsor’s compliance with all Medicare program requirements. Sponsors must ensure that employees are aware of the Medicare requirements related to their job function. [Chapter 21 – Rev. 109, 50.3; Additional Compliance Training Requirements can be found at §§ 50.3.1 and 50.3.2]</p>
Element 4 – Communication Lines	
Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities: Compliance and ethics program - 42 CFR § 483.85	Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the [Social Security] Act by any of the operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data. [42 CFR § 483.85(c)(6)]
Publication of the OIG Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987 (Feb. 23, 1998)); Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858 (Jan. 31, 2005))	The maintenance of a process, such as a hotline , to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation. [63 Fed Reg. 8987, 8989 [1998]; 70 Fed. Reg. 4858, 4875 [2005]]
New York Social Services Law § 363-d	Communication lines to the responsible compliance position, as described in paragraph (b) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified. [SSL § 363-d (2)(d)]
U.S. Sentencing Commission Guidelines Manual 2016	The organization shall take reasonable steps— to have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization’s employees and agents may report or seek guidance regarding potential or actual criminal conduct without fear of retaliation. [8B2.1(b)(5)(C)]
DSRIP Compliance Program Elements	The PPS Lead must establish a process of reporting compliance issues to its Compliance Officer, which must include an anonymous and confidential method of reporting. [OMIG DSRIP Compliance Guidance at 3]
Medicare Managed Care Manual (2013)	The sponsor must establish and implement effective lines of communication, ensuring confidentiality between the compliance officer, members of the compliance committee, the sponsor’s employees, managers and governing body, and the sponsor’s FDRs. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith

	reporting of potential compliance issues as they are identified. [Chapter 21 – Rev. 109, 50.4; Additional information regarding Lines of Communication can be found at §§ 50.4.1 and 50.4.2]
Element 5 – Disciplinary Policies	
Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities: Compliance and ethics program - 42 CFR § 483.85	Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program. [42 CFR § 483.85(c)(7)]
Publication of the OIG Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987 (Feb. 23, 1998)); Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858 (Jan. 31, 2005))	The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals. [63 Fed Reg. 8987, 8989 [1998]; 70 Fed. Reg. 4858, 4876 [2005]]
New York Social Services Law § 363-d	Disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for: (1) failing to report suspected problems; (2) participating in non-compliant behavior; or (3) encouraging, directing, facilitating or permitting non-compliant behavior; such disciplinary policies shall be fairly and firmly enforced. [SSL § 363-d (2)(e)]
U.S. Sentencing Commission Guidelines Manual 2016	The organization's compliance and ethics program shall be promoted and enforced consistently throughout the organization through (A) appropriate incentives to perform in accordance with the compliance and ethics program; and (B) appropriate disciplinary measures for engaging in criminal conduct and for failing to take reasonable steps to prevent or detect criminal conduct. [8B2.1 (b)(6)]
DSRIP Compliance Program Elements	The PPS Lead's policies and procedures must include disciplinary policies and procedures to encourage good faith participation in the compliance program by all affected individuals. [OMIG DSRIP Compliance Guidance at 3]
Medicare Managed Care Manual (2013)	Compliance policies and/or procedures are detailed and specific, and describe the operation of the compliance program. Compliance policies may address issues such as sponsors' compliance reporting structure, compliance and FWA training requirements, the operation of the hotline or other reporting mechanisms, and how suspected, detected or reported compliance and potential FWA issues are investigated, addressed, and remediated. Sponsors should update the policies and procedures to incorporate changes in applicable laws, regulations, and other program requirements. [Chapter 21 – Rev. 109, 50.1.2; Additional information regarding policies and/or procedures can be found at §§ 50.1.3 and 50.1.1]
Element 6 – Routine Identification of Compliance Risk	
Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities: Compliance and ethics program - 42 CFR	The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Social Security Act by any of the

<p>§ 483.85</p>	<p>operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data. [42 CFR § 483.85(c)(6)]</p>
<p>Publication of the OIG Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987 (Feb. 23, 1998)); Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858 (Jan. 31, 2005))</p>	<p>The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area. [63 Fed Reg. 8987, 8989 [1998]; 70 Fed. Reg. 4858, 4875-4876 [2005]]</p>
<p>New York Social Services Law § 363-d</p>	<p>A system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including 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. [SSL § 363-d (2)(f)]</p>
<p>U.S. Sentencing Commission Guidelines Manual 2016</p>	<p>The organization shall take reasonable steps— (A) to ensure that the organization’s compliance and ethics program is followed, including monitoring and auditing to detect criminal conduct; (B) to evaluate periodically the effectiveness of the organization’s compliance and ethics program; and (C) to have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization’s employees and agents may report or seek guidance regarding potential or actual criminal conduct without fear of retaliation. [8B2.1(b)(5)(A)(B)(C)]</p> <p>In implementing subsection (b) of 8B2.1 of the U.S. Sentencing Commission Guidelines Manual (2016), the organization shall periodically assess the risk of criminal conduct and shall take appropriate steps to design, implement, or modify each requirement set forth in subsection (b) to reduce the risk of criminal conduct identified through this process. [8B2.1(c)]</p>
<p>DSRIP Compliance Program Elements</p>	<p>The PPS Lead must develop and implement a system for routine identification of compliance risk areas specific to their provider type (i.e. PPS Lead). [OMIG DSRIP Compliance Guidance at 3]</p>
<p>Medicare Managed Care Manual (2013)</p>	<p>Sponsors must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the sponsor’s, including FDRs’, compliance with CMS requirements and the overall effectiveness of the compliance program. [Chapter 21 – Rev. 109, 50.6; Additional information regarding identification of compliance risks can be found at §§ 50.6.1, 50.6.2, and 50.6.3]</p>
<p>Element 7 – System for Responding to Compliance Issues</p>	
<p>Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities: Compliance and ethics program - 42 CFR § 483.85</p>	<p>After a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act. [42 CFR § 483.85(c)(8)]</p>
<p>Publication of the OIG Compliance Program</p>	<p>The development of a system to respond to allegations of improper/ illegal activities and the enforcement of</p>

<p>Guidance for Hospitals (63 Fed. Reg. 8987 (Feb. 23, 1998)); Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858 (Jan. 31, 2005))</p>	<p>appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements. [63 Fed Reg. 8987, 8989 [1998]; 70 Fed. Reg. 4858, 4876 [2005]]</p>
<p>Social Services Law § 363-d</p>	<p>A system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments. [SSL § 363-d(2)(g)]</p>
<p>U.S. Sentencing Commission Guidelines Manual 2016</p>	<p>After criminal conduct has been detected, the organization shall take reasonable steps to respond appropriately to the criminal conduct and to prevent further similar criminal conduct, including making any necessary modifications to the organization’s compliance and ethics program. [8B2.1(b)(7)]</p>
<p>DSRIP Compliance Program Elements</p>	<p>The PPS Lead must develop and implement a system for responding to compliance issues that are raised. A PPS Lead should consider its own willful misuse of DSRIP funds, or false statements made by a PPS Lead or its network providers to obtain DSRIP funds, as examples of compliance issues. The PPS Lead’s system must also include a method for prompt corrective action and refunding overpayments. [OMIG DSRIP Compliance Guidance at 3]</p>
<p>Medicare Managed Care Manual (2013)</p>	<p>Sponsors must establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements. (1) If the sponsor discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct. (2) The sponsor must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible individuals) in response to the potential violation referenced above. (3) The sponsor should have procedures to voluntarily self-report potential fraud or misconduct related to the Medicare program to CMS or its designee (such as the NBI MEDIC). [Chapter 21 – Rev. 109, 50.7; Additional information can be found at §§ 50.7.1, 50.7.2 and 50.7.3]</p>
<p>Element 8 – Whistleblower Protection</p>	
<p>Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities: Compliance and ethics program - 42 CFR § 483.85</p>	<p>The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the [Social Security] Act by any of the operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data. [42 CFR § 483.85(c)(6)]</p>
<p>Publication of the OIG Compliance Program</p>	<p>The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to</p>

<p>Guidance for Hospitals (63 Fed. Reg. 8987 (Feb. 23, 1998)); Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858 (Jan. 31, 2005))</p>	<p>protect the anonymity of complainants and to protect whistleblowers from retaliation. [63 Fed Reg. 8987, 8989 [1998]; 70 Fed. Reg. 4858, 4875 [2005]]</p>
<p>New York Social Services Law § 363-d</p>	<p>A policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the New York State Labor Law. [SSL § 363-d(2)(h)]</p>
<p>U.S. Sentencing Commission Guidelines Manual 2016</p>	<p>The organization shall take reasonable steps— (A) to ensure that the organization’s compliance and ethics program is followed, including monitoring and auditing to detect criminal conduct; (B) to evaluate periodically the effectiveness of the organization’s compliance and ethics program; and (C) to have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization’s employees and agents may report or seek guidance regarding potential or actual criminal conduct without fear of retaliation. [8B2.1(b)(5)(A)(B)(C)]</p>
<p>DSRIP Compliance Program Elements</p>	<p>PPS Leads must develop a policy of non-intimidation and non-retaliation for good faith participation in the compliance program. PPS Leads will also need to work with their network partners to support compliance with this requirement. [OMIG DSRIP Compliance Guidance at 4]</p>
<p>Medicare Managed Care Manual (2013)</p>	<p>Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials. [Chapter 21 – Rev. 109, § 50.1]</p>

Exhibit I³

ACO Compliance Elements	
Element 1	Designation of a compliance officer who reports directly to the ACO governing body. (<i>See</i> 42 C.F.R. § 425.300[a][1])
Element 2	Establishment of a system to identify compliance problems concerning the performance and operations of the ACO. (<i>See id.</i> at § 425.300[a][2])
Element 3	A confidential reporting system that facilitates anonymous reports of compliance problems by ACO employees, contractors, providers, suppliers, participants, as well as other persons or entities who or that perform ACO related functions (collectively hereinafter “ACO Participants”). (<i>See id.</i> at § 425.300[a][3])
Element 4	The availability of compliance training for ACO participants. (<i>id.</i> at § 425.300[a][4])
Element 5	A policy and process that mandates the ACO to report “probable violations of law to an appropriate law enforcement agency.” (<i>Id.</i> at § 425.300 [a][5]).

³ This Exhibit I outlines the elements included in the compliance plan for Accountable Care Organizations, codified at 42 C.F.R. § 425.300.

Exhibit II

NYC Health + Hospitals/Gotham is required to satisfy the compliance requirements under the Public Health Service Act (“PHS Act”) and its implementing regulations, the HRSA-approved co-applicant agreement between Gotham Health FQHC, Inc. and the System, and HRSA policies including, without limitation, the HRSA Health Center Program – *Health Center Program Compliance Manual* (the “Compliance Manual”).

The Compliance Manual, which is “a consolidated resource to assist [H]ealth [C]enters in understanding and demonstrating compliance with Health Center Program requirements”, identifies compliance requirements in 21 chapters. A brief summary of some of the key compliance requirements is provided in the table below. The Compliance Manual may be found here:

<https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf>.

HRSA Health Center Program Compliance Manual	
Title	Compliance Program Requirement
Chapter 1: Health Center Program Eligibility	The Federally Qualified Health Care Center (“FQHC” or “Health Center”) applying for funding must qualify as an eligible organization under the Health Center Program statute and regulations.
Chapter 2: Health Center Program Oversight	The Health Center must comply with all requirements of the Health Center Program and applicable laws, and is subject to the administrative oversight of the Health Resources and Services Administration (“HRSA”)/Bureau of Primary Health Care (“BPHC”).
Chapter 3: Needs Assessment	The Health Center must define and annually review the boundaries of the catchment area to be served [service area], including the identification of the medically underserved population or populations within the catchment area. In performing this assessment, the Health Center must assess the need for health services in the catchment area of the center based on the population.
Chapter 4: Required and Additional Health Services	<p>The Health Center must provide the required primary health services listed in section 330 (b)(1) of the PHS Act. A Health Center that receives a Health Center Program award or look-alike designation under section 330 (h) of the PHS Act to serve individuals experiencing homelessness must, in addition to these required primary health services, provide substance abuse services.</p> <p>The Health Center may additionally provide (supplemental) health services that are appropriate to meet the health needs of the population served by the Health Center, subject to review and approval by HRSA. It is important to point out that, a Health Center which serves a population that includes a substantial proportion of individuals of limited English-speaking ability, must make plans and arrangements to meet</p>

	the needs of this population.
Chapter 5: Clinical Staffing	The Health Center must ensure that the services rendered are available and accessible promptly, as appropriate, and in a manner that will assure continuity of service to the residents of the center's catchment area. The Health Center must utilize staff that are qualified by training and experience to carry out the activities of the center.
Chapter 6: Accessible Locations and Hours of Operation	The required primary health services of the Health Center must be available and accessible in the catchment [service] area of the center promptly, as appropriate, and in a manner which ensures continuity of service to the residents of the center's catchment area.
Chapter 7: Coverage for Medical Emergencies During and After Hours	To assure continuity of the required primary health services of the center, the Health Center must have: (i) provisions for promptly responding to patient medical emergencies during the Health Center's regularly scheduled hours; and (ii) clearly defined arrangements for promptly responding to patient medical emergencies after the Health Center's regularly scheduled hours.
Chapter 8: Continuity of Care and Hospital Admitting	The Health Center must provide the required primary health services of the center promptly and in a manner which will assure continuity of service to patients within the center's catchment area (service area). The Health Center must develop an ongoing referral relationship with one or more hospitals.
Chapter 9: Sliding Fee Discount Program	The Health Center must operate in a manner such that no patient shall be denied service due to an individual's inability to pay. The Health Center must establish systems for [sliding fee] eligibility determination.
Chapter 10: Quality Improvement/Assurance	The Health Center must have an ongoing quality improvement/assurance (QI/QA) system that includes clinical services and [clinical] management and maintains the confidentiality of patient records. Specifically, the Health Center must maintain the confidentiality of patient records, including all information as to personal facts and circumstances obtained by the Health Center staff about recipients of services.
Chapter 11: Key Management Staff	The Health Center must maintain key management staff at a level sufficient to carry out the Health Center's activities. The Health Center must maintain position descriptions for such key management staff that sets forth the qualifications for training and experience that are necessary to carry out the activities of the Health Center. Prior approval from HRSA must be obtained before changing the key person specified in the Health Center's program award or look-alike designation.

<p>Chapter 12: Contracts and Subawards</p>	<p>The Health Center must determine whether an individual agreement that will result in disbursement of Federal funds will be carried out through a contract or a subaward and structure the agreement accordingly.</p>
<p>Chapter 13: Conflict of Interest</p>	<p>The Health Center must maintain written standards of conduct covering conflicts of interest and governing the actions of its employees engaged in the selection, award, or administration of contracts that comply with all applicable Federal requirements. No employee, officer, or agent of the Health Center may participate in the selection, award, or administration of a contract supported by a Federal award if he or she has a real or apparent conflict of interest. The Health Center’s standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the Health Center.</p>
<p>Chapter 14: Collaborative Relationships</p>	<p>The Health Center has made and must continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the Health Center’s catchment area [service area]. To the extent possible, the Health Center must coordinate and integrate project activities with the activities of other federally-funded, as well as State and local, health services delivery projects and programs serving the same population.</p>
<p>Chapter 15: Financial Management and Accounting Systems</p>	<p>The Health Center must: (i) maintain effective control over, and accountability for, all funds, property, and other assets in order to adequately safeguard all such assets and ensure that they are used solely for authorized purposes; and (ii) develop and utilize financial management and control systems in accordance with sound financial management procedures which ensure at a minimum: (a) the fiscal integrity of grant financial transactions and reports; and (b) ongoing compliance with Federal statutes, regulations, and the terms and conditions of the Health Center Program award or designation.</p>
<p>Chapter 16: Billing and Collections</p>	<p>The Health Center must prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation. Any fees or payments shall be reduced or waived in order to assure that no patient will be denied such services due to an individual’s inability to pay for such services. The Health Center must establish systems for eligibility determination and for billing and collections with respect to third party payors.</p>
<p>Chapter 17: Budget</p>	<p>The Health Center must develop an annual budget that:</p> <ul style="list-style-type: none"> • Identifies the projected costs of the Health Center Program project; • Identifies the projected costs to be supported by Health Center Program [award] funds, consistent with Federal Cost Principles and any other requirements or restrictions on the use of Federal

	<p>funding; and</p> <ul style="list-style-type: none"> • Includes all other non-Federal revenue sources that will support the Health Center Program project, including: <ul style="list-style-type: none"> ○ State, local, and other operational funding; and ○ Fees, premiums, and third-party reimbursements which the Health Center may reasonably be expected to receive for its operation of the Health Center Program project.
<p>Chapter 18: Program Monitoring and Data Reporting Systems</p>	<p>The Health Center must establish systems for monitoring program performance to ensure: (i) oversight of the operations of the Federal award [or designation]-supported activities in compliance with applicable Federal requirements; (ii) performance expectations [as described in the terms or conditions of the Federal award or designation] are being achieved; and (iii) areas for improvement in program outcomes and productivity [efficiency and effectiveness] are identified.</p>
<p>Chapter 19: Board Authority</p>	<p>The Health Center must establish a governing board that has specific responsibility for oversight of the Health Center Program project. Some of the board’s responsibilities include:</p> <ul style="list-style-type: none"> • The Health Center governing board must develop bylaws which specify the responsibilities of the board. • The Health Center governing board must assure that the center is operated in compliance with applicable Federal, State, and local laws and regulations. • The Health Center governing board must have authority for establishing or adopting policies for the conduct of the Health Center Program project and for updating these policies when needed. Specifically, the Health Center governing board must have authority for adopting and establishing specified policies. • The Health Center governing board must review and approve the annual Health Center Program project budget. • The Health Center governing board must ensure that a process is developed for hearing and resolving patient grievances.
<p>Chapter 20: Board Composition</p>	<p>There are various compliance requirements that the Health Center must satisfy with regard to Board Composition. A list of some of these compliance requirements is provided below:</p>

	<ul style="list-style-type: none"> • The Health Center’s governing board must consist of at least 9 and no more than 25 members. • The majority [at least 51 percent] of the Health Center board members must be patients served by the Health Center. These Health Center patient board members must, as a group, represent the individuals who are served by the Health Center in terms of demographic factors, such as race, ethnicity, and gender. • Non-patient Health Center board members must be representative of the community served by the Health Center and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. • Of the non-patient Health Center board members, no more than one-half may derive more than 10 percent of their annual income from the health care industry. • A Health Center board member may not be an employee of the center, or spouse or child, parent, brother or sister by blood or marriage of such an employee. The project director [Chief Executive Officer (CEO)] may be a non-voting, ex-officio member of the board. • The Health Center bylaws or other internal governing rules must prescribe the process for selection and removal of all governing board members. This selection process must ensure that the governing board is representative of the Health Center patient population. The selection process in the bylaws or other rules is subject to approval by HRSA.
<p>Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements</p>	<p>In order to obtain deemed Public Health Service (“PHS”) employment status under the PHS Act, the Health Center must submit an annual deeming application for approval by HRSA.</p>

ATTACHMENT V-a

**NYC HEALTH + HOSPITALS
PRINCIPALS OF PROFESSIONAL CONDUCT (“POPC”)**





NYC HEALTH + HOSPITALS

PRINCIPLES OF PROFESSIONAL CONDUCT



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NYC HEALTH + HOSPITALS

PRINCIPLES OF PROFESSIONAL CONDUCT

I. POPC OVERVIEW.

The *Principles of Professional Conduct* (“POPC”) is a guide that sets forth NYC Health + Hospitals’ compliance expectations and commitment to comply with all applicable Federal and State laws. It describes NYC Health + Hospitals’ standards of professional conduct and efforts to prevent fraud, waste, and abuse. All NYC Health + Hospitals workforce members and business partners, as described in Section II below, are expected to carry out their duties and functions in a manner that is lawful and ethical. Workforce member responsibilities under the POPC are listed in Section IV below, and business partner responsibilities under the POPC are listed in Section V below.

II. WHO DOES THE POPC APPLY TO?

The POPC applies to and governs the conduct of: (i) NYC Health + Hospitals workforce members (whether permanent or temporary), including all NYC Health + Hospitals employees, members of the Board of Directors, personnel, affiliates, medical staff members, volunteers, students, and trainees, throughout all NYC Health + Hospitals facilities, units, and entities; and (ii) NYC Health + Hospitals business partners who are required by law or contract to comply with this POPC, including the POPC’s core objectives specified in Section III below. Business partners include OneCity Health/Delivery System Reform Incentive Payment (“DSRIP”) Program partners as well as contractors, subcontractors, agents and other persons or entities that, on behalf of NYC Health + Hospitals, provide billing or coding functions, furnish health care services or items, or monitor the health care provided by NYC Health + Hospitals.

III. POPC CORE OBJECTIVES.

The core objectives of the POPC are to ensure that NYC Health + Hospitals workforce members and, as applicable, its business partners:

- Fulfill NYC Health + Hospitals’ mission;



- 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 humane care and respect;
 - Promote and protect, as both an innovator and advocate, the health, welfare and safety of the people of the State of New York and of the City of New York; and
 - 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 of the State of New York and of the City of New York;
- Uphold NYC Health + Hospitals’ values by continuously reinforcing the six essential features of our daily work outlined in NYC Health + Hospitals *Guiding Principles*;
 - Keep patients first;
 - Keep everyone safe;
 - Work together;
 - Pursue excellence;
 - Manage your resources; and
 - Keep learning;
 - Prevent, identify, and correct unlawful and unethical behavior and fraud, waste, and abuse;
 - Identify, assess, and monitor potential risk areas;
 - Adhere to all applicable provisions of Federal and State law, NYC Health + Hospitals’ Corporate Compliance and Ethics Program, and NYC Health + Hospitals’ policies, including provisions that require the reporting of violations to appropriate parties;
 - Prevent the submission of inappropriate claims and billings and the receipt of improper payments by implementing training initiatives, establishing internal controls, and carrying out auditing and monitoring activities; and



- Minimize financial loss and reduce the likelihood of an overpayment by a federal health program, governmental entity or other third party payor;
- Deliver high quality, medically necessary care and services to all individuals in need regardless of their ability to pay;
 - Ensure that only health practitioners and other health professionals who are duly licensed, certified, credentialed or otherwise qualified in accordance with Federal and State law, medical staff bylaws and associated rules, and internal policies, are authorized to deliver care to patients;
 - Respect and protect patients' rights;
 - Deliver care and services in a culturally sensitive manner; and
 - Strive for the highest level of patient satisfaction;
- Maintain a respectful, healthy, productive, and safe work environment with the goals of preventing discriminatory and other inappropriate forms of conduct, reducing the likelihood of illnesses and injuries, and helping workforce members realize their full potential;
 - Provide equal employment opportunities to all workforce members and employment candidates regardless of any protected characteristic including, without limitation, race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or any other any other protected class covered by Federal, State, and/or local anti-discrimination laws;
 - Promptly respond to and address all acts or threats of violence, intimidation, discrimination, harassment or disruptive behavior;
 - Encourage workforce members to realize their full potential;
 - Provide reasonable accommodations to workforce members with disabilities; and
 - Perform initial and periodic health screenings of workforce members as required by applicable law and internal policies;
- Facilitate and promote standards of conduct that detect, reduce, and/or effectively manage conflicts of interest;



- Respect the environment in which we work and our facilities operate;
 - Handle, use, and dispose of all toxic, hazardous, radioactive, and pharmacological agents, materials, instruments, and supplies in a safe manner consistent with applicable law and internal policies;
- Establish mandatory compliance and other training and education initiatives;
- Engage in only fair business practices;
- Maintain an information governance program wherein patient, billing, employment, and other business records are authenticated and maintained in accordance with NYC Health + Hospitals' record management, privacy, and data security policies;
 - Ensure that all business records are kept securely, recorded accurately, authentic when produced, and available when needed;
 - Protect patient and workforce member privacy and confidentiality; and
 - Provide notice to patients and other affected parties as required by applicable law and internal policies in the case of a breach of confidential information;
- Participate in the NYC Health + Hospitals Corporate Compliance and Ethics Program and promptly report compliance concerns;
- As a condition of employment or contract (or other agreement), comply with the POPC and, where appropriate, other NYC Health + Hospitals policies that relate to the types of services, duties, functions, and products that the workforce member and/or business partner provides;
- Prohibit and promptly report to appropriate parties allegations of retaliation, harassment or intimidation in response to workforce member, business partner or other stakeholder participation in the Corporate Compliance and Ethics Program;



- Establish and enforce fair and consistent disciplinary policies and procedures for workforce member and, to the extent applicable, business partner violations of law or NYC Health + Hospitals policies;
- Provide NYC Health + Hospitals/MetroPlus Health Plan members with access to the highest quality, cost-effective health care including a comprehensive program of care management, health education, and customer service;
 - Strive for performance excellence by holding the Plan and its providers to the highest standards to ensure that members receive quality care;
 - Engage in team work, including all human resources and providers, to deliver the highest quality care and services to members
 - Achieve superior provider, member, and employee satisfaction;
 - Be fiscally responsible and ensure that revenues received are used effectively;
 - Foster a culture of respectfulness in the way everyone who is encountered is treated;
 - Protect member rights; and
 - Be accountable to each other, members, and providers; and
- Adhere to all NYC Health + Hospitals/MetroPlus Health Plan’s contractual commitments with Federal and State regulatory agencies;

IV. WHAT ARE THE RESPONSIBILITIES OF WORKFORCE MEMBERS UNDER THE POPC?

All workforce members are required to carry out their functions and duties - whether delivering clinical care, assisting in coding, billing or claims reimbursement activities, providing administrative oversight of NYC Health + Hospitals’ operations, or acting as support personnel - in a professional and ethical manner. This means, each workforce member is responsible for the following:



- Not engaging in any acts, conduct or practice that would be contrary to any of the core objectives listed in Section III above or interfere with NYC Health + Hospitals achieving any of these core objectives;
- Following the POPC and other applicable NYC Health + Hospitals policies and procedures, and applicable law;
- Not engaging in unprofessional conduct, examples of which are provided in Section VI below;
- Completing assigned training and education programs;
- Fully cooperating with any internal or government investigation; and
- Reporting, as outlined in Section VIII below, any event, occurrence, activity or other incident that appears to violate applicable law or NYC Health + Hospitals policies and procedures.

Workforce members must understand and comply with the applicable rules and policies that relate to their particular duties, functions or role. If a workforce member does not know what rules or policies apply to his/her position, that workforce member should talk to his/her supervisor, manager, administrative head or chief of service.

V. WHAT ARE THE RESPONSIBILITIES OF NYC HEALTH + HOSPITALS BUSINESS PARTNERS UNDER THE POPC?

It is the expectation of NYC Health + Hospitals that each entity with which it partners to accomplish its mission: (i) adopts the POPC or their own code of conduct that includes the POPC's core objectives or substantially similar compliance goals; (ii) not violate the POPC or their own similar code; (iii) not engage in unprofessional conduct as described in Section VI below; (iv) timely reports to NYC Health + Hospitals any violation of the POPC of which it becomes aware; and (v) fully cooperates, to the extent applicable, with any investigation by NYC Health + Hospitals or, if required, any governmental agency.



VI. WHAT ARE SOME EXAMPLES OF UNPROFESSIONAL CONDUCT?

The following are some examples of unprofessional conduct and are prohibited by NYC Health + Hospitals:

- Submitting false and/or fraudulent claims;
- Improper billing practices, including, but not limited to:
 - Billing for items or services not rendered or those that are not medically necessary;
 - Upcoding - using a billing or DRG code that provides for a higher payment rate than the correct code;
 - Submitting multiple claims for a single service or submitting a claim to more than one primary payor at the same time;
 - Unbundling - submitting claims in a piecemeal or fragmented way to improperly increase payment;
- Failing to promptly report and refund, as required by law, any overpayment;
- Interfering with or otherwise impeding an internal or government investigation;
- Submitting false cost reports;
- Failure to deliver medical care to any individual based on their inability to pay;
- Failure to comply with laws governing workplace safety;
- Engaging in conduct that is discriminatory in nature, amounts to sexual or other harassment, or constitutes intimidation, as well any act or threat of violence;
- Engaging in conduct that is hazardous to the environment;



- Engaging in conflicts of interest;
 - Accepting gifts or services from a patient, vendor or potential vendor;
 - Unlawfully donating hospital funds, services and products, or other resources to any political cause, party or candidate;
 - Failing to comply with the Chapter 68 of the New York City Charter or the NYC Health + Hospitals Code of Ethics to the extent such conflicts of interest policies apply;
- Failure to complete mandated training;
- Failure to maintain accurate, clear, and comprehensive medical records;
- Improperly using, disclosing, accessing, transmitting, and/or storing patient, workforce member or business information;
- Entering into an agreement with a business partner or affiliate the terms of which: (i) do not call for compliance with the POPC; or (ii) provide for activities and services that constitute unprofessional conduct;
- Engaging in business practices and acts that are unfair, deceptive or anti-competitive;
- Conducting unlawful marketing practices to enroll members into NYC Health + Hospitals/MetroPlus Health Plan including, but not limited to, engaging in unlawful beneficiary inducements;
- Failure to promptly report a potential compliance concern or incident;
- Submitting false statements, certifications, qualifications and/or documentation required in any business dealings or one's role;
- Any violation of Federal and State human subject research laws and/or the NYC Health + Hospitals Human Subject Research Protections Program Policies and Procedures;



- Any violation of applicable NYC Health + Hospitals' policies and procedures;
- Other types of unprofessional conduct, including, but not limited to:
 - Misuse or misallocation of World Trade Center Health Program, DSRIP Program, research or grant funds;
 - Engaging in improper or illegal business arrangements;
 - Giving or receiving anything of value to induce referrals for items or services, or for the ordering of items or services;
 - Hiring or contracting with persons or entities excluded from participation in Federal health care programs; and
 - Engaging in any activity or conduct that may result in the imposition of civil monetary penalties.

VII. WHAT HAPPENS IF YOU ENGAGE IN UNPROFESSIONAL CONDUCT OR OTHERWISE VIOLATE THE POPC?

Workforce members or business partners who engage in unprofessional conduct or act contrary to applicable law or NYC Health + Hospitals' policies and procedures, many of which are summarized in the POPC core objectives or other elements of the POPC, shall be subject to disciplinary action up to and including termination of employment, contract, and/or other affiliation with NYC Health + Hospitals, as applicable.

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VIII. HOW TO REPORT ISSUES OR VIOLATIONS.

Workforce members and business partners, as applicable, are responsible for promptly reporting to the Office of Corporate Compliance any suspected unlawful or unethical behavior or incidents and/or violations of the POPC. Reports may be made, by phone, fax or e-mail in the following manner:

NYC Health + Hospitals
Office of Corporate Compliance
160 Water Street, Suite 1129
New York, NY 10038
Telephone: (646) 458-7799
Facsimile: (646) 458-5624
E-mail: COMPLIANCE@nychhc.org
Confidential Compliance Helpline: 1-866-HELP-HHC (1-866-435-7442)

Reports may be made anonymously by using the **CONFIDENTIAL COMPLIANCE HELPLINE** provided directly above. Each report received by will be treated confidentially, fully assessed, and investigated as warranted.

IX. PROHIBITION OF RETALIATION/WHISTLEBLOWER PROTECTION.

NYC Health + Hospitals is committed to protecting whistleblowers. Accordingly, NYC Health + Hospitals strictly prohibits intimidation, harassment, or retaliation, in any form against any individual who in good faith participates in the Corporate Compliance and Ethics Program by reporting or participating in the investigation of suspected violations of law, regulation, policies and/or suspicions of fraud, waste, or abuse. Examples of retaliation include unjustified discharge/termination, demotion, or suspension of employment; threatening or harassing behavior; and/or negative or onerous change in any term or condition of employment.

Any attempt by an individual or entity to intimidate, harass, or retaliate against a reporter or potential reporter will result in action up to and including termination of employment, contract, and/or other affiliation with NYC Health + Hospitals.



X. STAY INFORMED!

Workforce members and business partners are strongly encouraged to familiarize themselves with NYC Health + Hospitals' mission, values, *Guiding Principles*, and to stay informed of the many NYC Health + Hospitals policies related to the POPC's core objectives by visiting its intranet page at: <http://compliance.nychhc.org/>, or NYC Health + Hospitals' public website at: <http://www.nychealthandhospitals.org/hhc/html/about/About-PublicInfo-Compliance.shtml>. Questions regarding these policies or any of the following important topics, may be addressed by contacting the Office of Corporate Compliance as described in Section VIII above:

- NYC Health + Hospitals Corporate Compliance and Ethics Program;
- Stark Law, Anti-Kickback Statute, State and Federal False Claims Acts, Civil Monetary Penalties Law, Exclusion Authorities, Criminal Health Care Fraud Statute, and New York Labor Law §§ 740 and 741;
- Billing, coding, payments, accounting, and record keeping;
- Conflicts of interest;
- Customer and vendor relations;
- Discrimination, sexual harassment, and retaliation;
- Patient rights;
- HIPAA and patient confidentiality;
- Workplace safety and environment of care issues;
- Improper business arrangements (e.g., leases) or referrals; and
- Information governance.



ATTACHMENT V-b

NYC HEALTH + HOSPITALS

**PRINCIPLES OF PROFESSIONAL CONDUCT
FREQUENTLY ASKED QUESTIONS (“POPC FAQs”)**



NYC HEALTH + HOSPITALS
PRINCIPLES OF PROFESSIONAL CONDUCT
FREQUENTLY ASKED QUESTIONS (“FAQs”)

1. What is the POPC?

Section I [**POPC Overview**] of the NYC Health + Hospitals *Principles of Professional Conduct* (“POPC”) describes the POPC as a guide that:

- (i) Sets forth NYC Health + Hospitals’ (the “System”) compliance expectations and commitment to comply with all applicable Federal and State laws;¹ and
- (ii) Describes the System’s standards of professional conduct (*i.e.*, code of conduct) and efforts to prevent fraud, waste, and abuse.

2. Who does the POPC apply to?

As noted in POPC Section II [**Who Does the POPC Apply To?**], the POPC applies to all System Workforce Members and Business Partners as described below:

- (i) Workforce Members (whether permanent or temporary) include, without limitation, the following individuals:
 - employees;
 - members of the Board of Directors;²

¹ State law includes New York State law, as well as applicable local law.

² For purposes of the POPC, “members of the Board of Directors” shall mean: (i) Members of the NYC Health + Hospitals Board of Directors; and (ii) all Directors of wholly owned subsidiaries of the System. Note that, the POPC also applies to all members of the Gotham Health FQHC, Inc., Board of Directors.



- personnel;
- affiliates;³
- medical staff members;
- volunteers;
- students; and
- trainees.

Note that, for purposes of the POPC, the term “personnel” includes, without limitation, interns, appointees, executives, and any individual whose conduct, in the performance of duties and functions on behalf of the System, is under the direct control of the System, whether or not such individual is paid by the System.

(ii) Business Partners include, without limitation, the following:

- All OneCity Health/Delivery System Reform Incentive Payment (“DSRIP”) Program partners; and
- All non-workforce member contractors, subcontractors, agents, and other persons or entities (collectively “Third Parties”) that on behalf of the System:
 - provide billing or coding functions;
 - furnish (e.g., deliver, prescribe, direct, order or otherwise provide or authorize the provision thereof) health care services (e.g., patient care) or items (e.g., supplies); or
 - monitor the health care provided by the System.

³ The terms “affiliates” and “affiliate personnel” as used in this document shall mean all all affiliate employees and other affiliate personnel who, pursuant to an affiliation agreement with the System, serve as *Contract Service Providers* and perform on behalf of the System *Contract Services*, as both of these italicized terms are defined under such corresponding affiliation agreement.



It is important to highlight that the list of Business Partners specifically mentioned in the POPC is not an exhaustive list. Rather, as per the specific provisions of the POPC, Business Partners also include any third party required by law or contract to comply with the POPC. Under both the System's internal policies governing contracts and applicable law, this includes, for example, third parties that, in acting on behalf of, or otherwise being associated with, the System:

- Engage in activities, functions, and duties that: (i) contribute to the System's entitlement to receive payment from Federal healthcare programs; or (ii) may place the System in a position to commit significant noncompliance with Federal health care program (e.g., Medicare, Medicaid and Tricare) or private payor requirements or fraud, waste and abuse prohibitions;
- Establish and administer the formulary and/or medical benefit coverage policies and procedures;
- Review beneficiary claims and services submitted for payment; and
- Exercise decision making authority (e.g., clinical decisions, coverage determinations, appeals and grievances, health plan enrollment/disenrollment functions, the processing of pharmacy or medical claims).

3. Does the POPC Apply to all System agents?

YES – Consistent with applicable State and Federal Law, the POPC, which is one of several written policies promulgated by the System to deter fraud, waste, and abuse, applies to all System agents. Agents are individuals or entities that have established an agency relationship with the System. For purposes of the POPC, agents may fall under the definition of Workforce Members or Business Partners, as such terms are defined in POPC Section II and further clarified in FAQ # 2 above.



4. I work in the intensive care unit (“ICU”) as a nurse at one of the System’s acute care facilities - - does the POPC apply to me? Does it apply to the physicians that work with me in the ICU?

YES to both questions - Pursuant to POPC Section II [**Who Does the POPC Apply To?**], the POPC applies to and governs the conduct of all Workforce Members at each System facility, unit, and entity. Thus, all System nurses and physicians, as well as all other healthcare professionals (e.g., podiatrists, dentists, optometrists, physician assistants, pharmacists, respiratory therapists, occupational therapists, social workers, psychologists, clinical laboratory technologists, mental health counselors, social workers, and physical therapists), whether permanent, temporary, full-time, part-time or per diem, are all considered Workforce Members and are therefore subject to the provisions of the POPC.

5. Why is the POPC required?

The POPC is required under New York State (“State”) law as a condition of the System’s participation in the Medicaid program. Additionally, Federal agency guidance recommends the promulgation of the POPC by the System.

Specifically, under the State Social Services Law and related regulations covering mandatory provider compliance programs, the System is required to establish “written policies and procedures that describe compliance expectations as embodied in a code of conduct or [a] code of ethics.”⁴ The POPC, which serves as the System’s standards of professional conduct, meets this criterion.

Federal agency guidelines, *i.e.*, U.S. Department of Health and Human Services Office of Inspector General *Compliance Program Guidance for Hospitals* and the United States Sentencing Commission Guidelines Manual discuss standards of conduct for organizations like the System.⁵ The POPC, serving as the System’s

⁴ Social Services Law § 363-d (2)(a); 18 NYCRR § 521.3(c)(1).

⁵ See Department of Health and Human Services Office of Inspector General (“OIG”), *Publication of the OIG: Compliance Program Guidance for Hospitals*, § II (A)(1), 63 Fed. Reg. 8987, 8989-8990 (Feb. 23, 1998); see also 2016 United States Sentencing Commission Guidelines Manual, § 8B2.1 (b)(1) & 8B2.1 *Commentary: Application Notes*, at n.1 [standards and procedures defined].



standards of professional conduct, meet these guidelines, which are considered industry best practices.

As stated in POPC Section I [**POPC Overview**], all System Workforce Members and Business Partners are expected to perform their duties and functions in a manner that is lawful and ethical. To this end, the POPC is required to inform Workforce Members and Business Partners of their responsibilities and what is expected of them, from a compliance, ethics and professionalism standpoint when they are carrying out their System duties, functions, and obligations. In this regard, the POPC serves as a “constitution” in that it outlines the System’s essential principles, values, and attitudes.⁶

6. Does the POPC alter or otherwise change my existing job responsibilities?

NO - the POPC is a summary of the System’s commitment to conduct its business, clinical, and administrative operations in an ethical and lawful manner. All Workforce Members and Business Partners have been and will continue to be responsible for:

- (i) complying with all applicable laws;
- (ii) following the System’s policies and procedures that relate to their work role, functions, duties, responsibilities, and, where applicable, contractual obligations; and
- (iii) refraining from engaging in unprofessional conduct, examples of which are provided in POPC Section VI [**What Are Some Examples of Unprofessional Conduct**].

7. What do I need to do to comply with the POPC?

Generally, to comply with the provisions of the POPC, all Workforce Members and Business Partners are required to:

⁶ See, generally, OIG, OIG Supplemental Compliance Program Guidance for Hospitals, § III (A), 70 Fed. Reg. 4858, 4874 (Jan. 31, 2005).



- (i) Follow the core objectives outlined in POPC Section III [**POPC Core Objectives**], which include, for example, the following:
- Fulfilling the System’s mission and upholding the System’s values;
 - Preventing, identifying, and correcting unlawful and unethical behavior and fraud, waste and abuse;
 - Maintaining a respectful, healthy, productive, and safe work environment;
 - Delivering high quality, medically necessary care and services to all individuals regardless of their ability to pay; and
 - Adhering to all NYC Health + Hospitals/MetroPlus Health Plan’s contractual commitments with Federal and State regulatory agencies;
- (ii) Refrain from engaging in unprofessional conduct as set forth in POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**]. Unprofessional conduct includes, for example, the following:
- Submitting false and/or fraudulent claims;
 - Engaging in improper billing practices;
 - Failing to comply with laws governing workplace safety;
 - Engaging in conflicts of interest;
 - Failing to report a potential compliance concern or incident;
 - Violating Federal and State human subject research laws and/or the System’s Human Subject Research Protections Program Policies and Procedures;
 - Failing to maintain accurate, clear, and comprehensive medical records; or



- Improperly using, disclosing, accessing, transmitting, and/or storing patient, workforce member or business information.
- (iii) Report suspected unlawful or unethical behavior or incidents and/violations of the POPC as provided in POPC Section VIII **[How to Report Issues or Violations]**;
- (iv) Fully cooperate with any internal or government investigation; and
- (v) Refrain from engaging in any form of retaliatory conduct, as described in POPC Section IX **[Prohibition of Retaliation/Whistleblower Protection]**, against any individual who in good faith participates in the Corporate Compliance and Ethics Program.

8. *What happens if a Workforce member or Business Partner engages in unprofessional conduct or otherwise violate the POPC?*

As outlined in POPC Section VII **[Disciplinary Action]**, any Workforce Member or Business Partner who engages in unprofessional conduct, including but not limited to, violating the POPC, Federal or State laws or the System's policies and procedures, shall be subject to disciplinary action up to and including termination of employment, contract, and/or other affiliation with the System, as applicable.

9. *My department has similar policies for professional conduct, must I still adhere to the POPC?*

YES - along with your specific department policies, you are required to comply with the standards of professional conduct outlined in the POPC. The POPC applies to all Workforce Members, Business Partners, and Agents of each System facility, unit, and entity including, without limitation, the following:

- (i) All acute care facilities and associated extension clinics;
- (ii) All diagnostic and treatment centers ("D & TCs") (including all D & TCs designated as Federally Qualified Healthcare Centers) and associated extension clinics;
- (iii) All long-term acute care facilities and nursing homes;



- (iv) NYC Health + Hospitals/At Home; and
- (v) All subsidiary corporations of the System.

Note that, some System subsidiaries (e.g., MetroPlus Health Plan, HHC ACO, Inc.) may have promulgated additional standards of professional conduct that are tailored to address the program nuances and regulatory requirements particular to these subsidiaries. Under such circumstances, Workforce Members, Business Partners, and Agents of these subsidiaries are required to follow all applicable provisions of both the POPC and other standards of professional conduct enacted by such subsidiaries.

It is also important to highlight that all System physicians and other healthcare professionals (examples of which are provided herein at question # 4 above) who are licensed under Title VIII of the State's Education Law are required to adhere to the professional standards established by the Office of Professions of the State Education Department, as applicable.⁷ Conduct by health professionals that runs afoul of these standards constitutes professional misconduct under State law, and in turn, is a violation of POPC Section IV [**What are the Responsibilities of Workforce Members Under the POPC**], which provides that Workforce Members must not engage in any acts, conduct or practice that would be contrary to the POPC's core objectives. One of the core objectives of the POPC (see Section III, [**POPC Core Objectives**]) is that all Workforce Members and Business Partners adhere to all applicable provisions of Federal and State law. Thus, a violation by a healthcare professional of one or more of the professional standards promulgated by the New York State Department of Education is a violation of State law and in turn a violation of the POPC.

⁷ See NY Education Law §§ 6509 (definitions of professional misconduct for all professions), 6510 (professional misconduct proceedings) 6511 (penalties for professional misconduct) 6530 (definitions of professional misconduct for physicians, medical residents, physician assistants, specialist assistants); see also 8 NYCRR §§ 29.1 (General provisions), 29.2 (General provisions for health professions), and 29.4 to 29.19 (special provisions for the professions of medicine, dentistry and dental hygiene, pharmacy, optometry, ophthalmic dispensing, psychology, nursing, social work, physical therapy, midwifery).



10. What are some examples of System policies that address conflicts of interest?

Before we review the System's policies that cover conflicts of interest, it is important to first highlight that one of the core objectives of the POPC (see Section III, [**POPC Core Objectives**]) is to detect, reduce, and manage conflicts of interests. Likewise, it is deemed Unprofessional Conduct under POPC Section VI [**What are some Examples of Unprofessional Conduct**] to engage in conflicts of Interests.

Pursuant to Article XIX of the *NYC Health + Hospitals By-laws*, all Workforce Members are subject to the following standards of conduct/conflicts of interest policies that govern the relationship between the private interests of Workforce Members and their official System duties:⁸

- (i) Chapter 68 of the Charter of the City of New York (also called the New York City Conflicts of Interest Law), which applies to all:
 - System employees; and
 - Members of the System's Board of Directors and all Directors of each of the System's wholly owned subsidiaries.
- (ii) NYC Health + Hospitals Code of Ethics, which applies to all:

⁸ See Article XIX [Conflicts of Interest] of the NYC Health + Hospitals By-laws, available at: <http://www.nychealthandhospitals.org/wp-content/uploads/2016/07/hhc-bylaws-2015.pdf>; see also Chapter 68 of the New York City Charter (which includes, without limitation, rules regarding: (i) accepting gifts; (ii) personal use of City property; (iii) misuse of City position, time, resources, personnel, and/or letterhead for personal gain; (iv) outside businesses and employment; (v) volunteer work; (vi) political activities; (vii) restrictions on lobbyists giving gifts to public servants; and (viii) post-City employment) available at http://www.nyc.gov/html/conflicts/downloads/pdf2/books/blu_bk.pdf; NYC Health and Hospitals Corporation Code of Ethics (January 1983, reissued June 1997), available at <http://www.nychealthandhospitals.org/wp-content/uploads/2016/07/HHC-Code-of-Ethics-1.pdf>; see also, generally, New York City Conflicts of Interest Board Publication, *Ethics: A Plain Language Guide to Chapter 68 of the New York City Charter: Conflicts of Interest Law* (February 2017), available at: http://www.nyc.gov/html/conflicts/downloads/pdf2/books/orange_bk.pdf.



- members of the System’s community advisory boards;
- members of the System’s auxiliaries;
- System affiliate personnel; and
- other System personnel who are not covered by Chapter 68.⁹

Additionally, all System employees are subject to System OP 20-55 (*Pharmaceutical Company Gifts and Sponsored Educational Programs*), which, consistent with employee obligations under the Conflicts of Interest Law, sets forth the System’s policy on gifts from pharmaceutical and other companies that provide or intend to provide medical supplies and/or equipment to the System.

Pursuant to the System’s Code of Ethics, the restrictions found under OP 20-55 also apply to each Workforce Member listed under subdivision (ii) of this section that is not directly covered by OP 20-55. Likewise, by way of the POPC, as well as Board Member obligations under the System’s By-laws and COIB law, the restrictions found in OP 20-55 also apply to each Member of the System’s Board of Directors and each Director of a wholly-owned System subsidiary that is not directly covered by OP 20-55.

11. Is it a conflict of interest for a System employee to hold a second job?

YES - under the following circumstances:¹⁰

⁹ Note that, although the Code of Ethics states that it applies to the System’s “Board of Directors, its Officers, and employees (including medical staff), Corporation Hospital Auxiliaries, members of the Corporation’s Community Advisory Boards, and covered affiliate personnel”, this application is superseded by Article XIX [Conflicts of Interest] of the System’s By-laws, which specifically limits the application of the Code of Ethics to “all members of the [System’s] community advisory boards and its auxiliaries, and other personnel who are not covered by Chapter 68.” The term “other personnel”, as used in the By-laws, includes, without limitation, the System’s affiliates.

¹⁰ See NYC Conflicts of Interest Board, Monograph: Outside Activities, Wayne G. Hawley, § [D][1][full-time employment] & [D][2][part-time employment], available at: http://www.nyc.gov/html/conflicts/downloads/pdf2/mono/mono_outside_acts.pdf; see also Chapter 68 of the New York City Charter, § 2604 [b][2][providing that “[n]o public servant shall engage in any business,



- (i) If you work 20 hours or more for the System and the second employer has business dealings with the City of New York (the “City”) or the System; or
- (ii) If you work less than 20 hours for the System and the second employer has business dealings with the System.

More specifically, under the Conflicts of Interest Law, if you are a NYC Health + Hospitals employee working 20 hours or more per week, you must obtain prior permission in order to hold a concurrent second employment - - also referred to as moonlighting - - with a person, company, firm, organization, entity or any other third party that has business dealings with the City or the System. This includes any third party (including a private university) that:

- (i) Receives funding from the City or the System; or
- (ii) Contracts to sell goods or services to the City or the System; or is
- (iii) Licensed by the City or the System.

With regard to System employees who work less than 20 hours per week, the same rules apply except that it is permissible for the second job to be with a third party that has business dealings with the City, but it is impermissible for the second job to be with a third party that has business dealings with the System.

In order for an employee to seek authorization to moonlight for a Third Party that has business dealings with the City or the System, he/she must first obtain prior written approval from the System, and thereafter obtain a waiver from the Conflicts of Interest Board (“COIB”). To facilitate approval from the System and obtain a COIB waiver to moonlight, please contact Barbara Keller, Esq., First Deputy Counsel, Office of Legal Affairs, at: **(212) 788-3300**. Employees are hereby advised that all requests for moonlighting approvals and COIB waivers must follow this procedure or they will not be processed. Note that, the System reserves the right to enact and enforce internal policies and rules concerning moonlighting that are more stringent than the Conflict of Interest Law.

transaction or private employment, or have any financial or other private interest, direct or indirect, which is in conflict with the proper discharge of his or her official duties.”



Lastly, and equally as important as that provided above, employees bear the sole responsibility in confirming whether a third party who they wish to moonlight for has business dealings with the City or the System.

12. *I am a Workforce Member at a System acute care facility - - am I required to complete mandatory compliance and other System-wide or program specific training and education?*

YES - POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**] provides that all NYC Health + Hospitals Workforce Members and Business Partners at all System facilities, units, and entities must complete all assigned mandated trainings. Failure to complete mandatory trainings may result in negative performance evaluations and/or disciplinary action up to and including termination of employment, affiliation, or contract with NYC Health + Hospitals. In sum and substance, if you are a Workforce Member or Business Partner who performs duties and functions at, or services for, a System: (i) acute care facility, nursing home or long-term acute care facility or ambulatory care facility; (ii) unit such as, for example, Correctional Health Services, the World Trade Center Health Program, NYC Health + Hospitals At/Home; or (iii) subsidiary such as, for example, MetroPlus, OneCity Health, HHC ACO, Inc., you are required to complete all assigned System mandatory training and education programs.

13. *Who must participate in the NYC Health + Hospitals Corporate Compliance and Ethics Program?*

Consistent with POPC Section III [**POPC Core Objectives**], Section IV [**What are the Responsibilities of Workforce Members under the POPC**], Section V [**What are the Responsibilities of NYC Health + Hospitals' Business Partners Under the POPC?**], and Section VIII [**How to Report Issues or Violations**], all Workforce Members and Business Partners have an affirmative obligation to:

- (i) Participate in the Corporate Compliance Program (the "Program"); and



- (ii) Report violations of the Program promptly to the Office of Corporate Compliance (“OCC”).

Reports may be made, by phone, fax or e-mail in the following manner:

NYC Health + Hospitals
Office of Corporate Compliance
160 Water Street, Suite 1129
New York, NY 10038
Telephone: (646) 458-7799
Facsimile: (646) 458-5624

E-mail: COMPLIANCE@nychhc.org

Confidential Compliance Helpline: 1-866-HELP-HHC (1-866-435-7442).

Additional information regarding compliance reporting is provided in FAQ # 15, *infra*.

Note: The Chief Corporate Compliance Officer of NYC Health + Hospitals is Wayne A. McNulty.

14. Can I be retaliated against if I report a compliance violation?

NO - As stated in POPC Section IX [**Prohibition of Retaliation/Whistleblower Protection**], NYC Health + Hospitals strictly prohibits intimidation, harassment or retaliation, in any form, against any individual who in good faith participates in the Program by reporting or participating in the investigation of suspected violations of law, policies and/or suspicions of fraud, waste and abuse. Further, any attempt to intimidate or retaliate against a person who participates in the Program will result in action up to and including termination of employment, contract, and/or other affiliation with NYC Health + Hospitals.

15. Can I anonymously report unlawful or unethical conduct or other violations of the POPC?

YES - As outlined in POPC Section VIII [**How to Report Issues or Violations**], all Workforce Members and Business Partners may anonymously report any suspected unlawful or unethical behavior or incidents and/or violations of the



POPC, along with any other suspected compliance issues, by using the confidential Compliance Helpline at: **1-866-HELP-HHC (1-866-435-7442)**.

Note that, if a Workforce Member or Business Partner becomes aware of a potential or actual compliance violation involving NYC Health + Hospitals/OneCity Health's role as a performing provider system lead ("PPS Lead") in the New York State Department of Health Delivery System Reform Incentive Payment ("DSRIP") Program, or a violation by any OneCity Health Partner, such violation may be reported anonymously at: **1-844-805-0105**.

Additionally, Workforce Members who perform functions and duties at the wholly owned System subsidiary MetroPlus Health Plan ("NYC Health + Hospitals/MetroPlus" or "MetroPlus") may anonymously report compliance issues involving MetroPlus at: **1-888-245-7247**.

16. *I am a Workforce Member of NYC Health + Hospitals - - can I receive payment or other consideration for referring a patient to NYC Health + Hospitals?*

NO - It is deemed unprofessional conduct under POPC Section VI [**What Are Some Examples of Unprofessional Conduct**] (as well as a Workforce Member violation of the NYC Conflicts of Interest Law or the NYC Health + Hospitals Code of Ethics), for a Workforce Member or Business Partner to give or receive anything of value to induce referrals for items or services, or for ordering items or services.

Additionally giving or receiving anything of value to induce referrals or the ordering of items or services may violate Federal and/or State Anti-kickback laws.

17. *I am a Workforce Member of NYC Health + Hospitals - - may I accept gifts from pharmaceutical companies or vendors?*

NO - Besides gifts of nominal value, such as pens and calendars, gifts from pharmaceutical companies or vendors are prohibited and the acceptance of the same would violate POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**]. Cash gifts are never permitted, even those of



nominal value. It is also a violation of System OP 20-55 (*Pharmaceutical Company Gifts and Sponsored Educational Programs*) for a Workforce Member to accept gifts from pharmaceutical companies or other vendors (e.g., vendors that provide pharmaceuticals or other medical supplies or equipment). The New York City Conflicts of Interest Law and the NYC Health + Hospitals Code of Ethics also address accepting gifts from vendors.

18. *May Workforce Members or Business Partners of NYC Health + Hospitals accept gifts from patients?*

NO - Workforce Members and Business Partners of the System may never accept gifts or services, even gifts and services of nominal value, from patients. Such conduct would be deemed unprofessional conduct, as referred to in POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**].

19. *I am a physician at a NYC Health + Hospitals facility - - may I refer one of my patients to a physical therapy practice owned by my spouse?*

NO - A referral of this nature would be deemed to be unprofessional conduct as referred to in POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**], as it would constitute a conflict of interest. Under certain circumstances, such conduct may also violate the Stark law and constitute the engagement in an activity or conduct that may result in the imposition of civil monetary penalties.

Given the complexity surrounding this scenario, if a circumstance arises where a System physician is contemplating or otherwise considering making a referral to any medical facility or practice in which he or she (or a family member of such physician) has a financial relationship, said physician should refrain from doing the same and, instead, first contact the OCC (see question # 13 above for OCC contact information) or OLA, at (212) 788-3300, for further clarification and direction.



20. I am a member of the community advisory board - - do I have to adhere to the POPC? Do members of the Auxiliary have to adhere to the POPC?

YES to both questions - As a member of the community advisory board, you are deemed a volunteer of the System, as well as System personnel. As set forth under POPC Section II [**Who Does the POPC Apply To?**], the POPC applies to all System Workforce Members, including all members of the System’s Board of Directors, **personnel**, employees, affiliates, students, trainees and **volunteers** throughout all NYC Health + Hospitals facilities, units, and entities.

Members of the Auxiliary are likewise deemed to be both volunteers and personnel of the System and are therefore also subject to the POPC.

21. Can I email a patient’s protected health information (“PHI”) to a personal or non-NYC Health + Hospitals email account?

NO -. Emailing PHI or other forms of confidential information to a personal or non-System email account is strictly prohibited pursuant to System OP 250-19 (*HIPAA Security Policy- Transmission Security*), as well OP 250-19’s corresponding memorandum dated December 17, 2014, jointly issued by Enterprise Information Technology Services (“EITS”) and the Office of Corporate Compliance regarding “*Storage and Transmission of Electronic Protected Health Information (“EPHI”) and Other Confidential Information*” (collectively hereinafter, the “Transmission Policy”).

To elaborate further, the Transmission Policy prohibits the following:

- (i) Transmitting PHI (and any other confidential information, whether encrypted or not) from an NYC Health + Hospital’s e-mail account (currently Outlook) to the personal e-mail accounts (e.g., AOL, Yahoo, Gmail, etc.) of Workforce Members or others;
- (ii) Transmitting Confidential Information (whether encrypted or not) from the personal or other non-NYC Health + Hospital e-mail accounts of Workforce Members or others;



- (iii) Transmitting Confidential Information from NYC Health + Hospital e-mail accounts (currently Outlook) accounts to the outside e-mail accounts of NYC Health + Hospital's Business Partners or other vendors or regulatory bodies without using an approved secure method of file transmission; and
- (iv) Transmitting or uploading NYC Health + Hospital information (whether confidential or not) to non- NYC Health + Hospital operated or contracted cloud-based storage systems (e.g., Dropbox and Google Drive, etc.) without the prior written approval of NYC Health + Hospital's EITS.

Please be advised that PHI generally may only be transmitted to outside e-mail accounts of NYC Health + Hospital's Business Partners or other vendors that have a business associate agreement in place with NYC Health + Hospitals. If you are not sure whether the vendor to whom you wish to transmit PHI has a business associate agreement in place, please contact the OCC or OLA to confirm, before you transmit said information.

Finally, Workforce Members are required to maintain all business records in a manner that meets Federal and New York State record retention laws and is consistent with the System's internal policies and procedures as set forth in System OP 120-19 (*Corporate Record Management Program and Guidelines for Corporate Record Retention and Disposal*). To meet these legal and policy requirements, all System business records must remain at all times within the System's possession, custody or control and should not be, absent specific authorization to the contrary, stored at any non-System site whether in electronic or paper format.¹¹

Accordingly, business-related emails should not be produced on the personal email accounts of Workforce Members and should only be developed, generated,

¹¹ See Storage and Transmission of Electronic Protected Health Information ("E PHI") and other Confidential Information Memorandum dated December 17, 2014; see also OP120-19 (*Corporate Record Management Program and Guidelines for Corporate Record Retention and Disposal*) § XXXIII [**Storage of Records Onsite or at Facilities Maintained by Third Party Vendors**]. For these purposes a record is defined as any book, paper, map, photograph, microphotograph, other information recording device, or documentary medium, regardless of physical form, format or characteristic, that is drafted, made, produced, created, executed, or received by the System or any workforce member pursuant to law or relevant to the transaction of public business. See OP 120-19, § II (a).



transmitted and stored on System computers, servers, and email pathways (or through a secure remote virtual desktop modality established and approved by EITS).

Please note that in accordance with the Storage and Transmission Policy, Workforce Members have no expectation of privacy in any information or activity conducted, sent, performed, or viewed on or with System equipment or internet access. All System emails, whether generated within or outside of the System, remain the property of the System.

Based on the foregoing, the sending of System confidential emails to a personal or non--NYC Health + Hospitals email account would be deemed unprofessional conduct as referred to in POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**], since such conduct would result in:

- (i) The improper use, disclosure, access, transmission, and/or storing patient information or other confidential information, and
- (ii) Violation of applicable NYC Health + Hospital's Transmission Policy and Corporate Record Management Program.

22. Can I fax a patient's PHI to another health care provider for the purposes of treatment, payment or health care operations?

YES - However, under the HIPAA Privacy Rule, you must take reasonable safeguards when faxing PHI to protect the information from inappropriate access, use or disclosure.

For example, when faxing protected health information to a telephone number that is not regularly used, a reasonable safeguard may involve a provider first confirming the fax number with the intended recipient. Similarly, as provided in guidance issued by the U.S. Department of Health and Human Services Office for Civil Rights, a facility may consider pre-programming frequently used numbers directly into the fax machine to avoid the misdirection of PHI.¹² Additionally, all faxes should be accompanied with a cover sheet that:

¹² U.S. Department of Health & Human Services HIPAA for Professionals, Frequently Asked Questions:



- (i) Indicates that the information contained in the fax is confidential; and
- (ii) Indicates that in the event that a person other than the intended recipient receives the fax, the fax should be immediately disposed of (in a secure matter, of course) or destroyed (in a manner that renders the fax indecipherable) and the sender be notified.

Please be advised that, under POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**], it is a violation to improperly use, disclose, access, transmit, and/or store patient information.

23. *My mother is being treated at a NYC Health + Hospitals facility - - may I access her electronic medical record to see how she is doing if I am not part of her care team?*

No. Unless you are involved in the treatment of a patient, you are not permitted to access any patient’s medical record for any reason, not even if it is the record of a close family member or if it is your own medical record.

Please be reminded that it is a violation of POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**] to improperly use, access, disclose, store or transmit patient information. Note that, it is also a violation of the same provision of the POPC to improperly use, access, disclose, store or transmit Workforce Member or Business Partner information.

24. *I am a System employee who works at one of the System’s diagnostic and treatment centers. Can I be discriminated against because of my race, age, gender, gender identity, sexual orientation, religion, ethnicity, or disability?*

NO - NYC Health + Hospitals provides equal employment opportunities to all Workforce Members and employment candidates regardless of any protected characteristic including, without limitation, race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or any other protected class covered by Federal, State, and/or local anti-discrimination laws. One core objective of the POPC [See Section III – **POPC Core Objectives**] is to ensure that all Workforce Members and Business Partners maintain a respectful,

<https://www.hhs.gov/hipaa/for-professionals/faq/482/does-hipaa-permit-a-doctor-to-share-patient-information-for-treatment-over-the-phone/index.html>.



healthy, productive, and safe work environment with the goals of preventing discriminatory and other inappropriate forms of conduct.

25. *Some of my co-workers smoke in the locker room, is this allowed?*

NO - System OP 10-22 (*Smoke Free Policy*) prohibits smoking in all enclosed areas within the System's locations including all individually occupied offices, bathrooms, lobbies, vestibules, exits, hallways, stairwells in buildings and all System vehicles, garages, and any other enclosed space operated or controlled by the System. Smoking is also prohibited in the following outdoor areas: hospital grounds, within 15 feet of any hospital entrance or exit and within 15 feet of the entrance to or exit from any hospital grounds. This policy conforms to the New York City Smoke-Free Air Act¹³ and the New York State Clean Indoor Air Act.¹⁴ It should be noted that there are very few exceptions to this general rule. An exception exists pursuant to OP 10-22, §IV. D. for areas which are specifically designated as smoking lounges for patients of a residential healthcare facility or facility where day treatment programs are provided.¹⁵

Smoking in violation of the System's policy would be deemed unprofessional conduct pursuant to POPC Section VI [**What Are Some Examples of Unprofessional Conduct?**].

26. *I work in the emergency room at a NYC Health + Hospitals facility, can I turn away a patient who complains that she is having a medical emergency?*

NO - A patient who complains of an emergency medical condition may not be turned away. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires NYC Health + Hospitals to conduct a medical screening to determine if an emergency medical condition exists.¹⁶

¹³ New York City Administrative Code § 17-503 (c)(6); see *also* New York City Administrative Code Title 17, Chapter 5.

¹⁴ Public Health Law § 1399-o(2)(b); see *also* Public Health Law Article 13-E.

¹⁵ See NYC Administrative Code § 17-502(w) (defining a "[s]eparate smoking room").

¹⁶ 42 USC § 1395dd (a).



It is important to highlight that a core objective of the POPC [see Section III – **POPC Core Objectives**] is to ensure that all Workforce Members and Business Partners deliver high quality, medically necessary care and services to all individuals in need regardless of their ability to pay. Additionally, because a violation of EMTALA could lead to the imposition of Federal civil monetary penalties, such a violation would be deemed unprofessional conduct under POPC Section VI [**What Are Some Examples of Unprofessional Conduct**].

27. One of the core objectives listed under Section III of the POPC is that Workforce Members or Business Partners must respect and protect patients' rights. What are some examples of patient rights in System hospitals?

Examples of patients' rights include the right to:

- (i) receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age;¹⁷
- (ii) receive considerate and respectful care in a clean and safe environment free of unnecessary restraints;¹⁸
- (iii) a no smoking room;¹⁹
- (iv) receive complete information about their diagnosis, treatment, and prognosis;²⁰
- (v) receive all the information that they need to give informed consent for any proposed procedure or treatment; this information shall include the possible risks and benefits of the procedure or treatment.²¹
- (vi) be informed of the name and position of the doctor who will be in charge of their care in the hospital; and the name, position and function of any hospital staff involved in their care;²²

¹⁷ 10 NYCRR § 405.7(b)(2), (c)(2).

¹⁸ *Id.* at § 405.7(c)(3); see also 10 NYCRR § 405.7(b)(5).

¹⁹ 10 NYCRR § 405.7(c)(7); see also 10 NYCRR 405.7(b)(21)

²⁰ 10 NYCRR § 405.7(b)(8), (c)(8).

²¹ *Id.* at § 405.7(b)(9), (c)(9).

²² *Id.* at § 405.7(c)(5), (c)(6); see also 10 NYCRR § 405.7(b)(6), (b)(7).



- (vii) refuse treatment and refuse to take part in research;²³
- (viii) privacy while in the hospital and confidentiality of all information and records regarding their care;²⁴
- (ix) receive an itemized bill and explanation of all charges;²⁵ and
- (x) authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.²⁶

All patients at System hospital facilities are provided a copy of NYC Health + Hospitals' Patients' Bill of Rights regarding their admission and discharge. For a full copy of the Patients' Bill of Rights, please click [Patients' Bill of Rights](#).

28. I am a clinician at a NYC Health + Hospitals facility and would like to conduct clinical research. Does NYC Health + Hospitals have a policy or provide guidance on conducting clinical research?

YES - System OP 180-9 (*HHC Human Subject Research Protections Program Policies and Procedures*) governs the conduct of human subject research at the System. The procedures and guidelines for clinical research conducted at the System may be found in that operating procedure. The System is committed to conducting research with the highest regard for the welfare of human participants and assists investigators to be properly trained to develop and conduct research and to facilitate the appropriate conduct of research.

System OP 180-9 provides guidance to researchers in complying with the ethical standards described in the Belmont Report and applicable Federal and State laws and regulations that govern how research is to be conducted at any NYC Health + Hospitals facility, unit or entity.

²³ 10 NYCRR § 405.7(b)(10)(right to refuse treatment), (b)(18)(right to refuse to participate in research), (c)(11)(providing that patients have the right to “[r]efuse treatment and be told what effect this may have on [their] health.”), (c)(12)(providing that patients have the right to “[r]efuse to take part in research. In deciding whether or not to participate, [patients] have the right to a full explanation.”).

²⁴ *Id.* at § 405.7(b)(12)(right to privacy), (b)(13)(right to confidentiality), (c)(13)(right to privacy and confidentiality).

²⁵ *Id.* at § 405.7(c)(16).

²⁶ *Id.* at § 405.7(c)(18).



It is important to note that POPC Section VI **[What are Examples of Unprofessional Conduct]** provides that any violation of Federal and State human subject research laws and/or System OP 180-9 is considered unprofessional conduct and is prohibited by NYC Health + Hospitals.

29. *Where can I find more information about the POPC and the NYC Health + Hospitals Corporate Compliance and Ethics Program?*

As underscored in POPC Section X **[Stay Informed!]**, we encourage Workforce Members and Business Partners to familiarize themselves with the System’s mission, values, and *Guiding Principles*, and to stay informed about the numerous compliance policies and procedures related to the POPC’s core objectives by visiting the Office of Corporate Compliance (“OCC”) intranet page at: <http://compliance.nychhc.org/>, and the System’s public website at: <http://www.nychealthandhospitals.org/policies-procedures/>. On those pages you will find further information regarding the System’s Corporate Compliance and Ethics Program, as described below.

- (i) On the NYC Health + Hospitals/OCC intranet site (<http://compliance.nychhc.org/>), the following can be found:
- A general description of Corporate Compliance and the focus of the goals of the Corporate Compliance Program.
 - Elements of Compliance – An explanation of the eight key elements of an effective compliance program.
 - Overview of Compliance Areas including a brief description of the following: The Deficit Reduction Act (“DRA”) and how the System is complying with the requirements of the DRA, the False Claims Act, Chapter 68 of the Charter of the City of New York, commonly referred to as the “Conflicts of Interest Law”, Records Management, Code of Ethics, Fraud, Waste, & Abuse, Professional Conduct, as well as Clinical Documentation.



- Corporate Compliance Leadership and Team Members – The OCC intranet site provides a breakdown of the leadership and staff of the Office of Corporate Compliance.
 - Health Insurance Portability and Accountability Act (“HIPAA”) Overview – This area of the OCC intranet site includes information regarding HIPAA Privacy, Breach Notification and HIPAA Security, including the memorandum dated December 17, 2014 from EITS and the OCC regarding “Storage and Transmission of Electronic Protected Health Information (“EPHI”) and Other Confidential Information”..
 - General Training Information – The OCC intranet site also provides information about compliance training and how to obtain training for NYC Health + Hospitals’ Workforce Members.
- (ii) On the NYC Health + Hospitals/Public Website (<http://www.nychealthandhospitals.org/policies-procedures>), the following are some examples of compliance-related documents that can be found:
- Conflicts of Interest Policy, Chapter 68 of the Charter of the City of New York;
 - The System’s Code of Ethics – This outlines the standards of conduct governing the relationship between private interests and the proper discharge of official duties;
 - The memorandum from NYC Health + Hospitals’ Chief Corporate Compliance Officer regarding the Deficit Reduction Act of 2005 (“DRA”) – The DRA requires NYC Health + Hospitals establish written policies and procedures that inform workforce members about internal policies covering fraud, waste and abuse, the Federal False Claims Act and similar New York laws that govern false claims and statements and whistleblower protections. The notification provides a summary of these laws and explains how workforce members can obtain additional information;



- A Guide to Compliance at NYC Health + Hospitals – This guide provides a summary of important compliance issues, standards, and expectations at NYC Health + Hospitals;
 - Corporate Compliance Plan – This outlines and explains the structural and operational elements of its Corporate Compliance Program and NYC Health + Hospital’s goal of preventing fraud, waste, and abuse and deterring criminal conduct; and
 - Operating Procedure 50-1 Corporate Compliance Program – This OP describes the Program’s functions and operations.
- (iii) The NYC Health + Hospitals/OneCity Health/DSRIP public website (<http://www.onecityhealth.org/dsrp-compliance/>) contains the following DSRIP compliance related topics, including the below:

- DSRIP Partner Compliance Training.

The website contains memorandum describing the Delivery System Reform Incentive Payment (“DSRIP”) program compliance training and education requirements applicable to all performing providers (“Partners”) in the NYC Health + Hospitals-sponsored OneCity Health (“OneCity Health”) Performing Provider System (“PPS”). Attached to that memorandum is a PowerPoint presentation entitled Delivery System Reform Incentive Payment Program Compliance Training and Education covering the following core concepts:

- What is DSRIP and who are the key players?
- What is NYC Health + Hospitals/OneCity Health Performing Provider System?
- Why is the establishment of compliance program beneficial?
- What are the legally required elements of a compliance program?



- With regard to the required compliance program elements, what are the special considerations for DSRIP compliance?
 - What are the definitions of the terms Fraud, Waste & Abuse and corresponding examples of the same?
 - What are some of the Federal laws covering Fraud, Waste and Abuse that OneCity Health participants should be familiar with?
 - How can OneCity Health participants report a DSRIP-related compliance issue or concern?
- OneCity Health Partner Compliance Attestation:

The website also includes an attestation that must be completed by all OneCity Health Partners. The information provided by Partners in this attestation, including completion of DSRIP compliance training, will be utilized by OneCity Health to: *assess the compliance program integrity of its Partners; and satisfy OneCity Health's DSRIP Program compliance oversight obligations as they relate to the allocation of DSRIP funds.*



ATTACHMENT VI¹

**NEW YORK CITY CONFLICTS OF INTEREST BOARD
NEW YORK CONFLICTS OF INTEREST LAW, COVERING
NEW YORK CITY PUBLIC SERVANTS (PLAIN LANGUAGE VERSION)**

¹ The annexed document is a true copy of the New York City Conflicts of Interest Board (“COIB”) “Plain Language Version” of the New York City Conflicts of Interest Law. This document was accessed from the COIB website at: https://www1.nyc.gov/assets/coib/downloads/pdf2/leaflets/two_pg_guide.pdf





New York Conflicts of Interest Law, Covering New York City Public Servants
(Plain Language Version*)

1. **Misuse of Office.** Public servants may not use their position to personally or financially benefit themselves, their family members, or any person or firm with whom they have a business or financial relationship.
2. **Misuse of City Resources.** Public servants may not use City supplies, letterhead, telephone, e-mail, computer, equipment, resources, or personnel for any non-City purpose, nor may they pursue personal or private activities during times when they are required to work for the City.
3. **Gifts.** Public servants may not accept anything valued at \$50 or more from any person or firm that they know or should know is doing business or seeking to do business with the City.
4. **Gratuities.** Public servants may not accept anything from anyone other than the City for performing their official duties.
5. **Volunteer Activities.** Public servants may be officers or directors of a not-for-profit with business dealings with the City if they do this work on their own time, they are not compensated for such work, the not-for-profit has no dealings with their City agency (unless the agency head has given approval), and the public servant is in no way involved in the not-for-profit's business with the City.
6. **Seeking Other Jobs.** Public servants may not seek or obtain a non-City job with any person or firm with whom they are dealing with in their City job.
7. **Moonlighting.** Public servants may not have a job with any firm that they know or should know does business with the City or that receives a license, permit, grant, or benefit from the City. For certain part-time public servants, such as part-time members of boards and commissions, this prohibition applies only to their employing City agencies.
8. **Owning Businesses.** Public servants may not own any part of a business that they know or should know does business with the City or that receives a license, permit, grant, or benefit from the City, nor may their spouses, or their domestic partners, nor any of their children. For certain part-time public servants, such as part-time members of boards and commissions, this prohibition applies only to their employing City agencies.
9. **Permission to Moonlight or Own a Business.** Public servants may, with the written authorization of the head of their City agency, seek permission from the Board to have a job with a firm that does business with the City or to own some or all of a business that does business with the City.
10. **Disclosure and Recusal.** As soon as a public servant faces a possible conflict of interest under the City's conflicts of interest law, he or she must disclose the conflict to the Conflicts of Interest Board and comply with the Board's instructions, which may include recusal, divestiture, or other actions.
11. **Confidential Information.** Public servants may not disclose confidential City information or use it for any non-City purpose, even after they leave City service.
12. **Lawyers and Experts.** Public servants may not act as a lawyer or expert against the City's interests in any lawsuit brought by or against the City.

13. ***Appearances Before the City.*** Public servants may not accept anything from anyone other than the City for communicating with any City agency or for appearing anywhere on a City matter. For certain part-time public servants, such as part-time members of boards and commissions, this prohibition applies only to their employing City agencies.
14. ***Buying Office or Promotion.*** Public servants may not give or promise to give anything to anyone for being elected or appointed to City service or for receiving a promotion or raise.
15. ***Business with Subordinates.*** Public servants may not enter into any business or financial dealings with another public servant who is their subordinate or supervisor.
16. ***Political Solicitation of Subordinates.*** Public servants may not ask a subordinate to make a political contribution or to do any political activity.
17. ***Coercive Political Activity.*** Public servants may not force or try to force anyone to do any political activity.
18. ***Coercive Political Solicitation.*** Public servants may not directly or indirectly threaten anyone or promise anything to anyone in order to obtain a political contribution.
19. ***Political Activities by Certain High-Level Officials.*** Deputy mayors, agency heads, deputy or assistant agency heads, chiefs of staff, directors, or members of boards or commissions may not ask anyone to contribute to the political campaign of anyone running for City office or to the political campaign of a City elected official running for any office. These appointed officials, as well as elected officials, may not hold certain political party positions.
20. ***Post-Employment One-Year Ban.*** For one year after leaving City service, former public servants may not communicate with their former City agency on behalf of their new employer or business.
21. ***Post-Employment One-Year Ban for Certain High-Level Officials.*** Elected officials, deputy mayors, the chair of the City Planning Commission, and the heads of the Office of Management and Budget, Law Department, and Departments of Citywide Administrative Services, Finance, and Investigation, for one year after they leave City service, may not communicate with their former branch of City government on behalf of their new employer or business.
22. ***Post-Employment Particular Matter Bar.*** After leaving City service, former public servants may never work on a particular matter they personally and substantially worked on for the City.
23. ***Improper Conduct.*** Public servants may not take any action or have any position or interest, as defined by the Conflicts of Interest Board, that conflicts with their City duties.
24. ***Inducement of Others.*** Public servants may not cause, try to cause, or help another public servant to do anything that would violate the City's conflicts of interest law.

FOR ADDITIONAL INFORMATION, CONTACT
NEW YORK CITY CONFLICTS OF INTEREST BOARD
2 LAFAYETTE STREET, SUITE 1010
NEW YORK, NY 10007
212-442-1400
<http://nyc.gov/ethics>

* This material is intended as a general guide. It is not intended to replace the text of the law (City Charter § 2604). For more information or to obtain answers to specific questions, you may write or call the Board. Also, bear in mind that individual agencies may have additional restrictions on the acceptance of gifts, moonlighting, and other issues. Contact your agency's ethics liaison for more information.

ATTACHMENT VII

**NYC HEALTH + HOSPITALS CODE OF ETHICS
SUMMARY OF KEY PROVISIONS**



NYC HEALTH + HOSPITALS CODE OF ETHICS

SUMMARY OF KEY PROVISIONS

A. WHAT IS THE CODE OF ETHICS?

- 1) The Code of Ethics (the “Code”) is the standard of conduct promulgated by NYC Health + Hospitals (the “System”) to govern the relationship between private interests and the proper discharge of the official duties of members of the System’s community advisory boards, auxiliaries, and other personnel who are not covered by Chapter 68 of the Charter of the City of New York (“Chapter 68”).¹ It is similar to Chapter 68 in that the Code embodies an extensive recitation of acts that constitute conflicts of interest and are thereby prohibited.
- 2) The Code may be accessed on the System’s public website at: <http://www.nychealthandhospitals.org/wp-content/uploads/2016/07/HHC-Code-of-Ethics-1.pdf> , and the NYC Health + Hospitals/Office of Corporate Compliance’s intranet site at: http://sites.nychhc.org/counsel/COounsel_DOC/HHC_Code%20of%20Ethics.PDF .

B. TO WHOM DOES THE CODE OF ETHICS APPLY?

- 3) Pursuant to the System’s Bylaws, the Code applies to all personnel who are not System employees including members of the System’s Community Advisory Boards, auxiliaries, affiliate staff², and all other personnel not covered under Chapter 68.

C. CONFLICTS OF INTEREST

- 4) The Code provides a set of rules regarding potential conflicts of interest, which include but are not limited to the following:
 - Gifts: No person subject to the Code shall directly or indirectly solicit, accept, or receive any gift, whether in the form of money, service, loan, travel, entertainment, hospitality, thing, promise or in any other form, which could be perceived to have been intended to influence him/her in the performance of his/her official duties.
 - Use of Confidential or NYC Health + Hospitals Information: No person subject to the Code shall disclose confidential information acquired in the course of his or her official duties or use such information to further his or her personal interests.
 - Use of Position for Personal Gain: No person subject to the Code shall receive or enter into any agreement, expressed or implied, for compensation for services to be rendered, or whereby his or her compensation is to be dependent or contingent upon any action by the System with respect to such matter.

¹ Note that, although the Code of Ethics states that it applies to the System’s “Board of Directors, its Officers, and employees (including medical staff), Corporation Hospital Auxiliaries, members of the Corporation’s Community Advisory Boards, and covered affiliate personnel”, this application is superseded by Article XIX [Conflicts of Interest] of the System’s By-laws, which specifically limits the application of the Code of Ethics to “all members of the [System’s] community advisory boards and its auxiliaries, and other personnel who are not covered by Chapter 68.” The term “other personnel”, as used in the By-laws, includes, without limitation, all affiliate staff.

² The term “affiliate staff” shall mean all affiliate employees and other affiliate personnel who, pursuant to an affiliation agreement with the System, serve as *Contract Service Providers* and perform on behalf of the System *Contract Services*, as both of these italicized terms are defined under such corresponding affiliation agreement.

Code of Ethics

- Improper Business Arrangements: No person subject to the Code shall enter into any business or financial relationships with another covered person who is a superior or who is a subordinate of such covered person.
- Nepotism:
 - Whenever there are two or more relatives working in the same facility, no more than one of them shall be assigned to work in the same unit, even if no supervisory relationship exists.
 - No individual employed by the System shall be involved in hiring or employment of a near relative.
 - As similarly provided in OP 20-54 (Nepotism), the Code of Ethics provides that no Executive Director, Department Head, Cost Group Manager, Cost Center Manager, or their deputies, or individuals employed by the System shall supervise a near relative.

D. IMPROPER USE OF NYC HEALTH + HOSPITALS FUNDS AND ASSETS

5) Funds and assets of the System shall not be used for: legal or illegal political contributions; illegal or improper payments of any kind; or payments, gifts, or gratuities of any kind which indirectly or directly benefits any agent or employee of any entity with which the System does business. The funds and assets of the System shall be properly and accurately recorded on books and records in accordance with the generally accepted accounting principles.

E. HOW TO REPORT ISSUES OR VIOLATIONS

- 6) Please contact the NYC Health + Hospitals' Office of Corporate Compliance if you:
- Become aware of incident or circumstance that involves or appears to involve a conflict of interest;
 - Require guidance regarding the interpretation or application of a particular provision of the Code; or
 - Have any questions regarding the Code or this Summary.
- 7) Inquiries, requests for guidance, allegations or reports of conflicts of interest or other wrongdoing, and/or incident reporting may be made, by phone, fax or e-mail in the following manner:

NYC Health + Hospitals
Office of Corporate Compliance
160 Water Street, Suite 1129
New York, NY 10038
Telephone: (646) 458-7799
Facsimile: (646) 458-5624

E-mail: COMPLIANCE@nychhc.org

Confidential Compliance Helpline: 1 -866-HELP-HHC (1-866-435-7442)

OneCity Health DSRIP Compliance Helpline (for DSRIP-related compliance issues): 1-844-805-0105

MetroPlus Health Plan Compliance Hotline (for MetroPlus compliance issues) 1-888-245-7247

Note: This document is a summary guide and does not replace the specific language of *NYC Health + Hospitals Code of Ethics*. Please contact the Office of Corporate Compliance (see section 7 above) if you have any questions regarding this document, the *Code of Ethics*, or any compliance issue or concern. The full text of the *Code of Ethics* and the System's other standards of conduct, as well as related compliance policies, may be accessed on the System's public website at:

<http://www.nychealthandhospitals.org/policies-procedures/>.

ATTACHMENT VIII

**NYC HEALTH + HOSPITALS
CORPORATE COMPLIANCE AND ETHICS PROGRAM
OUTLINE OF DISCIPLINARY POLICY**



NYC HEALTH + HOSPITALS
CORPORATE COMPLIANCE AND ETHICS PROGRAM
OUTLINE OF DISCIPLINARY POLICY¹

I. Introduction

The NYC Health + Hospitals (the “System”) Corporate Compliance and Ethics Program (the “Program”) is focused on the prevention, detection, and correction of any departure from the System’s legal, regulatory, professional, fiduciary, and ethical obligations. All Workforce Members, Business Partners, and Agents (collectively “Covered Persons”), at each System facility, unit, and entity, are required to affirmatively participate in the Program by doing the following:

- Adhering to Compliance Standards;
- Committing to Ethical Conduct;
- Protecting the Privacy and Security of Confidential Information;
- Adhering to the System’s Standards of Conduct;
- Reporting suspected Compliance issues;

¹ This document is a summary guide and does not replace the specific language of Operating Procedure 50-1 - *Corporate Compliance and Ethics Program*, including but not limited to, § 23 **[Disciplinary Policy]**. Please contact the Office of Corporate Compliance by: (i) phone at (646) 458-5632 or 1-866-HELP-HHC (1-866-435-7442); or (ii) by email at COMPLIANCE@nychhc.org, if you have any questions regarding this outline or OP 50-1, or if you have any compliance issue or concern that you would like obtain guidance on and/or report. OP 50-1 may be accessed at: <http://www.nychealthandhospitals.org/wp-content/uploads/2016/07/OP-50-1-with-addendum.pdf>.



- Refraining from retaliating against whistleblowers; and
- Refraining from engaging in prohibited acts.

Those Covered Persons who fail to affirmatively participate in the Program shall be subject to sanctions and other forms of discipline as set forth in the Disciplinary Policy. The paragraphs that follow provide:

- An overview of New York State (“State”) compliance program requirements as they relate to disciplinary policies; and
- A detailed outline of the System’s Disciplinary Policy

II. Legal Requirements

In order to participate in the Medicaid program, the System must at all times operate and maintain an effective compliance program.² One of the required elements of an effective compliance program is the development and implementation of disciplinary policies that:³

- Articulate expectations for reporting compliance issues and assist in their resolution;
- Outline sanctions for the following:

² See 18 NYCRR § 521.1 (requiring an effective compliance program in order “[t]o be eligible to receive medical assistance payments for care, services, or supplies, or to be eligible to submit claims for care, services, or supplies for or on behalf of another person . . .”); see also OIG, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8988 (1998); OIG *Supplemental Compliance Program Guidance for Hospitals*, 70 Fed. Reg. 4858, 4859 (2005) (recommending that organizations implement a compliance program); United States Sentencing Commission Guidelines § 8B2.1 (2016) (same).

³ Social Services Law §363-d [2][e]; 18 NYCRR §521.3[c][5].



- Failing to report suspected problems;
 - Participating in non-compliant behavior; or
 - Encouraging, directing, facilitating, or permitting either actively or passively non-compliant behavior; and
- Are fairly and firmly enforced.

Accordingly, the System has established a Disciplinary Policy in § 23 of Operating Procedure (“OP”) 50-1 - *Corporate Compliance and Ethics Program*. All Covered Persons are subject to the Disciplinary Policy.

III. Overview

A. Goals of Disciplinary Policy

The System is committed to implementing and enforcing disciplinary policies, procedures, and practices necessary to:

- Encourage Covered Persons to actively participate in good faith with the Program⁴;
- Prevent or reduce the likelihood of the reoccurrence of Prohibited Acts, as defined below in § IV **[Examples of Prohibited Acts]**;
- Apply appropriate disciplinary actions to Covered Persons who fail to comply with the System’s policies and procedures or applicable laws; and
- Ensure that System senior administrators, managers, and supervisors, as part of their work duties and functions, establish a workplace environment

⁴ *Id.*



that encourages Covered Persons to report violations without fear of retaliation.⁵

B. Application of the Disciplinary Policy

A Covered Person who fails to comply with and/or affirmatively participate in the Program or engages in conduct that otherwise constitutes wrongdoing (collectively “Prohibited Acts”) shall be subject to sanctions or other disciplinary action (collectively “Disciplinary Action”). The Disciplinary Policy provides the framework, process and guidance on how appropriate Disciplinary Action shall: (i) be determined in a fair, equitable and consistent manner; and (ii) embody a process that respects and adheres to the due process, legal, contractual, and/or collective bargaining rights of Covered Persons.

IV. **Examples of Prohibited Acts**

If a Covered Person engages in a Prohibited Act, such Covered Person shall be subject to Disciplinary Action. Examples of Prohibited Acts include the following:

- Failing to perform their System functions, duties, and/or responsibilities in a legally compliant and ethical manner;
- Failing to report suspected compliance issues, problems, complaints, and incidents;⁶
- Participating in non-compliant behavior, for example, failing to comply with OP 50-1 or any other applicable NYC Health + Hospitals Operating Procedures or other policies or procedures;⁷
- Encouraging, directing, facilitating or permitting non-compliant behavior;⁸

⁵ See generally, OIG, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8995 § [II][D][1] (1998).

⁶ Social Services Law § 363-d[2][e][1]; 18 NYCRR §521.3[c][5][i]; New York State Department of Health, Office of the Medicaid Inspector General, *Compliance Program Guidance for General Hospitals* (May 11, 2012), Element 5 Requirement 2, Recommendations, § (B)(1)(a).

⁷ Social Services Law §363-d [2][e][2]; 18 NYCRR §521.3[c][5][iii].

⁸ Social Services Law §363-d [2][e][3]; 18 NYCRR §521.3[c][5][iii].



- Failing to comply with the System’s Standards of Conduct;
- Failing to complete assigned training and education programs;
- Failing to comply with applicable Federal and State laws and/or Federal healthcare program and private payer requirements;
- Engaging in intimidation or retaliation against any person who reports (or threatens to report) actual or suspected violations of the Program or otherwise participates in the Program;
- Refusing to cooperate with internal, governmental or regulatory investigations or audits,⁹ or failing to preserve records relevant to investigations;¹⁰
- Engaging in conduct that violates professional or clinical standards and/or obligations;¹¹
- Failing to protect the privacy and security of confidential patient, employee or System business information;
- Furnishing care and services, or creating or sanctioning conditions, that potentially endanger patients, Workforce Members, or the public;¹² and
- Engaging in any activity that has the potential to interfere with or otherwise negatively affect the policy and purpose of the Program.

⁹ New York State Department of Health, Office of Medicaid Inspector General, Compliance Program Guidance for General Hospitals (May 11, 2012), Element 5 Requirement 1, Recommendations, § [B][1][b].

¹⁰ *Id.* at Element 5 Requirement 1, Recommendations, § [B][1][d].

¹¹ *See generally*, 45 CFR § 164.502 (j)(1)(i); OIG, *OIG Supplemental Compliance Program Guidance for Hospitals*, 70 Fed. Reg. 4858, 4874 § [III][A] (2005).

¹² *See, generally*, 45 CFR § 164.502 (j)(1)(i); OIG, *OIG Supplemental Compliance Program Guidance for Hospitals*, 70 Fed. Reg. 4858, 4874 § [III][A] (2005).



V. Determination of Appropriate Disciplinary Action

In determining the appropriate Disciplinary Action of a Covered Person, the System applies consistent standards and considers various factors on a case by case basis.

A. Standards Applied in Determining Disciplinary Action

Disciplinary action consistently applied

- Disciplinary Action shall be enforced fairly, equitably and shall be applied consistently to all Covered Persons regardless of rank, profession, title, duty or function.¹³
- All Covered Persons shall potentially face the same level of Disciplinary Action for the commission of similar Prohibited Acts.¹⁴

Manager accountability

- Workforce Member supervisors and/or managers can be held accountable for the foreseeable compliance failures of their subordinates.¹⁵

Attendant facts shall determine the level of discipline

¹³ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals* 63 Fed. Reg. 8987, 8996, § [II][E][1] (1998) (“The consequences of noncompliance should be consistently applied and enforced, in order for the disciplinary policy to have the required deterrent effect. All levels of employees should be subject to the same disciplinary action for the commission of similar offenses.”); see also OIG, *Publication of the OIG Compliance Program Guidance for Nursing Facilities*, 65 Fed. Reg. 14289, 14303 (2000).

¹⁴ See 65 Fed. Reg. 14289, 14303 § [II][G] (2000) (providing that “[a]ll levels of employees should be potentially subject to the same types of disciplinary action for the commission of similar offenses”).

¹⁵ See 65 Fed. Reg. 14289, 14299 (2000); 63 Fed. Reg. 8987, 8996 § [II][E][1] (1998) (stating that “[t]he OIG believes that [workforce members] should be held accountable for failing to comply with, or for the foreseeable failure of their subordinates to adhere to, the applicable standards, laws, and procedures.”).



- Each commission of a Prohibited Act must be considered on a case by case basis when determining the appropriate course of Disciplinary Action that should be undertaken in response to such wrongdoing.¹⁶

B. Factors Considered in Determining Disciplinary Action

- The Disciplinary Action imposed shall be based on the nature and severity of the violation or misconduct.¹⁷
- When imposing discipline, one factor that may be considered is whether the Prohibited Act committed was part of a pattern or practice or an isolated incident.¹⁸
- Another factor that may be considered is whether the Prohibited Act is intentional or unintentional.¹⁹ For example, intentional or reckless noncompliance resulting from known conflicts of interests or from personal benefits gained by way of Prohibited Act, is likely to result in significant Disciplinary Action.²⁰

¹⁶ See *OIG, Publication of the OIG Compliance Program Guidance for Home Health Agencies* 63 Fed. Reg. 42410, 42422 § [II][E][1] (1998) (stating that, with regard to instances of noncompliance, “[e]ach situation must be considered on a case-by-case basis to determine the appropriate sanction.”); see also 65 Fed. Reg. 14289, 14303 § [II][G] (2000) (same).

¹⁷ See *Standards for Privacy of Individually Identifiable Health Information* 65 Fed. Reg. 82462, 82562 (2000); see also, generally, 63 Fed. Reg. 8987, 8995-8996 § [II][E][1] (1998).

¹⁸ See 65 Fed. Reg. 82462, 82562 (2000).

¹⁹ See 65 Fed. Reg. 82462, 82562 (2000); see also, generally, *OIG, Publication of the OIG Compliance Program Guidance for Hospitals* 63 Fed. Reg. 8987, 8995 § [II][E][1] (1998) (providing that “[i]ntentional . . . noncompliance should subject transgressors to significant sanctions.”); *OIG, Publication of the OIG Compliance Program Guidance for Nursing Facilities*, 65 Fed. Reg. 14289, 14303 § [II][G][1] (2000) (same).

²⁰ See generally, 63 Fed. Reg. 8987, 8995 § [II][E][1] (1998).



C. Determination of Disciplinary Action Must be In Accordance with Applicable Laws, Contracts, Collective Bargaining Agreements and System Policies

Any Disciplinary Action taken against a Covered Person who (or that) engages in a Prohibited Act shall be in accordance with applicable Federal and State law and as appropriate, the terms, conditions, and other provisions found in all applicable documents governing the relationship or other affiliation between the System and a Covered Person. This includes, for example the following:

- Employment contracts;
- Vendor contracts;
- Collective bargaining agreements;
- The System’s Personnel Rules and Regulations and other internal human resources and labor policies and procedures;
- Affiliation agreements and other arrangements;
- Medical staff bylaws; and
- Memoranda of understandings.

Accordingly, notwithstanding anything stated hereunder to the contrary, the term Disciplinary Action as used in OP 50-1, and likewise, this summary, is not intended to replace, modify, change or otherwise alter the definition of the same or similar term as it may be found in applicable collective bargaining agreements, employment or third-party contracts.

D. External Reporting

Disciplinary Action may trigger or include external reporting of certain misconduct to



governmental entities including but not limited to the New York State Office of Professional Misconduct (“OPMC”) and the Office of Professional Discipline (“OPD”).²¹

VI. Types of Disciplinary Action

The types of Disciplinary Action imposed for Covered Persons engaging in a Prohibited Acts fall into two categories: (i) informal; and (ii) formal.

A. Informal Disciplinary Action

Disciplinary Action may be informal in nature and involve the following:

- Corrective coaching;
- Education, retraining; and/or
- Remedial actions and measures.

B. Formal Disciplinary Action

Disciplinary Action may be formal in its application and may result in adverse employment, contractual or other actions taken by the System against a Covered Person.

VII. Examples of Disciplinary Action

A. Overview and General Examples

²¹ See, e.g., Public Health Law §230 [11][a] (required reporting to the New York State board for professional medical conduct of any information “which reasonably appears to show that a licensee is guilty of professional misconduct as defined in section sixty-five hundred thirty and sixty-five hundred thirty-one of the education law.”) and Public Health Law §2803-e [1]; see also 65 Fed. Reg. 14289, 14304 (2000) (the nursing facility “should promptly report the existence of misconduct to the appropriate Federal and State authorities within a reasonable period, but not more than 60 days after determining that there is credible evidence of a violation.”).



Examples of the Disciplinary Actions that Covered Persons may face include, but are not limited to, the following:

- Education, retraining or corrective coaching;
- Oral or written warnings regarding the Prohibited Act;²²
- Counseling;²³
- Financial penalties;²⁴
- Demotion in grade or title;²⁵
- Suspension without pay;²⁶
- The revocation of privileges as provided under the applicable facility Medical Staff Bylaws;²⁷ and
- Termination of employment, contract or other affiliation with NYC Health + Hospitals.²⁸

²² See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals* 63 Fed. Reg. 8987, 8995-8996 § [II][E][1], (1998); see also OIG, *Publication of the OIG Compliance Program Guidance for Nursing Facilities*, 65 Fed. Reg. 14289, 14303, [II][G][1] (2000); New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5 (a), available at: http://eig.nychhc.org/upload/MyDocuments/PersonnelRuleandRegs_opt.pdf.

²³ See OP 20-10 (Employee Performance and Conduct), § [IV][A], p.2.

²⁴ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals* 63 Fed. Reg. 8987, 8995-8996, § [II][E][1] (1998); see also 65 Fed. Reg. 14289, 14303 (2000); New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5 (b).

²⁵ New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5 (d).

²⁶ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8995-8996, § [II][E][1], (1998); see also New York City Health and Hospitals Corporation, *Personnel Rules and Regulations*, Rule 7.5 [Discipline], § 7.5.5 (c).

²⁷ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8995-8996, § [II][E][1] (1998).

²⁸ See OIG, *Publication of the OIG Compliance Program Guidance for Hospitals* 63 Fed. Reg. 8987, 8995-8996, § [II][E][1] (1998); see also 65 Fed. Reg. 14289, 14303 (2000); New York City Health and Hospitals Corporation,



B. Examples of Prohibited Acts That Will Most Often Result in the Most Severe Disciplinary Action

As stated above, in determining Disciplinary Action, factors considered include, without limitation, the following: (i) the nature and severity of the violation or misconduct; (ii) whether the Prohibited Act committed was part of a pattern or practice or an isolated incident; and (iii) whether the commission of the Prohibited Act was intentional or unintentional.

Generally, the System will most often seek immediate and prolonged suspension; revocation of privileges; reporting of the Prohibited Act to State licensing boards (where applicable); or the termination of an employment, contract or affiliation with the System in instances in which the Covered Person commits a Prohibited Act that has affected or may affect the following important System goals, principles and initiatives: (i) protecting patient, workplace and environmental safety; (ii) the System's mission to maintain a discrimination free patient care and work environment; (iii) the prevention of conduct involving fraud, waste, abuse, theft, corruption, and official misconduct; and (iv) the System's privacy and data security initiatives and the protection of employee and patient information confidentiality. A summary of these types of Prohibited Acts are provided below:

Protecting patient, workplace and environmental safety

- The System is committed to patient, workplace and environmental safety. The following are examples of Prohibited Acts relating to patient, workplace and environmental safety:
 - conduct that amounts to patient abuse;
 - the provision of clinical or other health services without proper license where a license is required by law;
 - intentional or reckless conduct that results (or has the potential to result) in serious injury or other harm to patients or Workforce

Personnel Rules and Regulations, Rule 7.5 [Discipline], § 7.5.5(e).



Members; and

- the improper and unsafe disposal of toxic, hazardous, radioactive, and pharmacological agents, materials, instruments and supplies.

Maintenance of discrimination free patient care and work environment

- The mission of the System is to maintain a discrimination free patient care and work environment. The following are examples of Prohibited Acts of discrimination:
 - conduct involving the refusal to provide care, or the provision of substandard care, based on a patient's race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or other protected characteristic covered by Federal, State or local anti-discrimination laws;
 - acts of discrimination in the workplace based on race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or other protected characteristic covered by Federal, State or local anti-discrimination laws;

The protection of the compliance integrity of the System and prevention of fraud waste, abuse, theft, corruption, and official misconduct.

- The System is committed to combatting fraud waste, abuse, theft, corruption, and official misconduct. The following are examples of Prohibited Acts relating to these issues:
 - the submission of false claims and the failure to return identified overpayments;



- the concealment or cover up of a civil or criminal violation of law or internal policy or procedure;
- the falsification of official System business records including, without limitation, medical records, billing records, employment records, and financial records;
- the theft of System property;
- the acceptance or offering of bribes or kickbacks or the engagement of official misconduct or other corrupt activities;
- the refusal to cooperate with an internal compliance investigation or other review;
- the engagement of conduct intended to thwart, stifle, suppress or otherwise interfere with an internal or external investigation into possible Program violations; and
- violations of the System's anti-retaliation/whistleblower protection policies.

The System's privacy and data security initiatives and employee and patient information confidentiality

- The System is committed to privacy and data security and employee and patient information confidentiality. The following are examples of Prohibited Acts relating to privacy, data security and confidentiality:
 - the unauthorized access, use or disclosure of System confidential information such as, for example, patient or employee information,



quality assurance information, proprietary information or information covered under the attorney-client privilege or other legally recognizable privileges, for monetary purposes or other personal gains or interests, or out of malice or to damage the reputation of the individual or entity to whom the confidential information pertains; and

- the commission of acts that violate Federal or State employee or patient confidentiality laws (and/or related internal System policies and procedures) and results in (or could result in) a breach of confidential information especially where such breach is significant and could lead to, or results in, harm of the affected individual or the System.

VIII. Implementation of the Disciplinary Policy

A. Individuals and Departments Involved in Determining Appropriate Disciplinary Action

Where an investigation results in a finding that credible evidence exists of a probable material commission of a Prohibited Act by a Covered Person, the System's Chief Compliance Officer ("CCO") shall provide guidance course of action to be considered by, as applicable:

- With respect to employees, The Human Resources and/or Labor Relations Departments;
- With respect to affiliate employees and affiliate personnel (e.g., affiliate subcontractors), the Office of Affiliations and /or the Office of Legal Affairs ("OLA") and the corresponding facility Chief Executive Officer; and
- With respect to vendors or Workforce members carrying out system activities for vendors, the Human Resource Department, Supply Chain, and OLA.



B. Compliance with Medical Staff Bylaws

With respect to members of the medical staff who have engaged in a Prohibited Act, guidance on a course Disciplinary Action to be considered may be made by CCO, Corporate or Facility Chief Medical Officer, Office of Legal Affairs, or Human Resources to the applicable Medical Staff Board President. Any corresponding action taken by the Medical Board shall be pursuant to and in compliance with the procedures, processes, and rules set forth in the applicable medical staff Bylaws.

C. Ongoing Monitoring of Disciplinary Action Compliance

- The Office of Corporate Compliance shall monitor and ensure the fair and consistent application of Disciplinary Actions for compliance violations to all Covered Parties regardless, of rank, profession, title, duty or function.²⁹
- Each matter involving the enforcement of disciplinary standards shall be expeditiously undertaken and thoroughly documented.³⁰
- NYC Health + Hospital Disciplinary Action policy shall be prominently publicized and made readily accessible to all Workforce Members, Business Partners, and Agents.³¹

D. System-wide internal policies, procedures, and practices to implement the Disciplinary Policy

With the advice and counsel of the OLA (and in consultation with the OCC), Human Resources, Labor Relations, Office of Affiliations, and Supply Chain shall establish uniform System-wide internal policies, procedures, and practices to implement the System's Disciplinary Policy.

²⁹ See *OIG, Publication of the OIG Compliance Program Guidance for Hospitals* 63 Fed. Reg. 8987, 8996, § [II][E][1] (1998) (“The consequences of noncompliance should be consistently applied and enforced, in order for the disciplinary policy to have the required deterrent effect. All levels of employees should be subject to the same disciplinary action for the commission of similar offenses.”); see also *OIG, Publication of the OIG Compliance Program Guidance for Nursing Facilities*, 65 Fed. Reg. 14289, 14303 (2000).

³⁰ See 70 Fed. Reg. 4858, 4876, § [III][B][7] (2005).

³¹ See *OIG 70 Fed. Reg. 4858, 4876, § [III][B][7] (2005).*



ATTACHMENT IX

**OVERVIEW OF NEW YORK LABOR LAW §§ 740 AND 741
AND OTHER WHISTLEBLOWER PROTECTION LAWS**



**OVERVIEW OF NEW YORK LABOR LAW §§ 740 AND 741 AND
OTHER WHISTLEBLOWER PROTECTION LAWS**

I. Introduction

NYC Health + Hospitals (the “System”) not only encourages its workforce members and business partners (“collectively “Covered Persons”) to report compliance issues, incidents, violations, and other concerns (collectively hereinafter referred to as “Compliance Concerns”), it requires such reporting as a condition of employment, contract and/or other affiliation with the System. Whistleblowers are those Covered Persons who, acting in good faith, report Compliance Concerns. The System is steadfast in protecting whistleblowers and has, accordingly, implemented and enforced a zero tolerance anti-retaliation policy. More specifically, as provided in § 24 of Operating Procedure (“OP”) 50-1 (*Corporate Compliance and Ethics Program* (the “Program”)), NYC Health + Hospitals strictly prohibits intimidation and retaliation in any form, against any Covered Person who, in good faith, participates in the Program, which includes, without limitation, engaging in any of the following activities:

- Reporting and investigating potential compliance issues and other concerns;
- Filing a compliance complaint;
- Making compliance inquiries;
- Conducting or cooperating with audits and internal investigations; and
- Objecting to or refusing to participate in any activity, policy or practice that violates applicable law or the NYC Health + Hospitals’ internal policies.

Furthermore, any Workforce Member or other individual or entity who or that is under contract, affiliation, or has established any other agreement with the NYC Health + Hospitals, that engages in retaliatory action against a whistleblower will be subject to discipline, up to and including termination of employment, contract, and/or other affiliation with the System as outlined in the Disciplinary Policy in § 23 of the OP 50-1.

In addition to the Whistleblower protections provided under OP 50-1, New York State (“State”) and Federal law may provide legal recourse for certain Covered Persons who may experience retaliation as a result of a good faith effort to participate in the Program. The sections that follow:

1. Provide an overview of State compliance program requirements as they relate to

whistleblower protections; and

2. Outline the following State and Federal whistleblower protection laws:
 - Labor Law §§ 740 & 741;
 - Federal False Claims Act (31 U.S.C. § 3730(h)); and
 - New York State False Claim Act (State Finance Law § 191)

II. Compliance Program Requirements

State law provides that an effective compliance program must have certain key elements, including without limitation, “a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections [740] and [741] of the [L]abor [L]aw.”¹ Labor Law §§ 740 and 741 are generally referred to as the New York State Whistleblower laws.

III. General Description of New York State Labor Law §§ 740 and 741

In general terms, Labor Law §§ 740 and 741 prohibit employers from taking retaliatory action against employees who, among other things, disclose or threaten to disclose to a supervisor or to a public body an activity, policy or practice of the employer:

1. That is in violation of law, rule or regulation, which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud;² or
2. Which the employee, in good faith, reasonably believes constitutes improper quality of patient care.³

IV. Retaliatory Action Defined

Generally, both §§ 740 and 741 define retaliatory action as the discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.⁴ Section 741 also includes penalization or discrimination against an employee in the terms and conditions of

¹ N.Y. Social Services Law § 363-d(2)(h); *see also* 18 N.Y.C.R.R. § 521.3(c)(8).

² N.Y. Labor Law § 740(2)(a).

³ N.Y. Labor Law § 741(2)(a).

⁴ N.Y. Labor Law §§ 740(1)(e) (defining the statutory term of “retaliatory personnel action” (emphasis added)), 741(1)(f).

employment in that definition.⁵

V. New York State Labor Law § 740: Retaliatory Personnel Action by Employers; Prohibition

A. Protected Employee Actions

New York Labor Law § 740 is generally referred to as the New York Whistleblower Law. Under § 740, an employer shall not take any retaliatory personnel action against an employee because such employee engages in any of the following protected actions:

1. Discloses, or threatens to disclose to a supervisor or public body an activity, policy or practice of the employer that is in violation of the law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud;⁶
2. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or⁷
3. Objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.⁸

B. Employee Defined

Employee is defined as an individual who performs services for and under the control and direction of the employer for wages or other remuneration.⁹

C. Employee Reporting Obligation

Before an employee can seek protection under § 740 for disclosure to a public body, the employee must have brought the activity, policy or practice in violation of law, rule or regulation to the attention of a supervisor of the employer and afforded such an employer a reasonable opportunity to correct such activity, policy or practice.¹⁰

D. Legal Remedies

Section 740 permits an employee to file a suit seeking, among other things, reinstatement to the same or equivalent position, reinstatement of seniority rights,

⁵ N.Y. Labor Law § 741(1)(f).

⁶ N.Y. Labor Law § 740(2)(a).

⁷ N.Y. Labor Law § 740(2)(b).

⁸ N.Y. Labor Law § 740(2)(c).

⁹ N.Y. Labor Law § 740(1)(a).

¹⁰ N.Y. Labor Law § 740(3).

compensation for lost wages or benefits, recoupment of reasonable costs, and attorney's fees.¹¹

E. Employer Defense

It is a defense to an action brought by an employee if the personnel action was based upon grounds other than the employee's exercise of any rights protected under § 740. For example, it is a defense if the employer can establish the termination was related to work performance.¹²

VI. **New York State Labor Law § 741: Prohibition; Health Care Employer Who Penalizes Employees because of Complaints of Employer Violations**

A. Protected Employee Actions

New York Labor Law § 741 is generally referred to as the New York Health Care Whistleblower Law. Labor Law §741 prohibits retaliatory action by health care employers. Specifically, § 741 provides that, notwithstanding any other provision of law, no health care employer shall take a retaliatory action against any employee because the employee engages in any of the following protected actions:

1. Discloses or threatens to disclose to a supervisor, or to a public body an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care; or
2. Objects to, or refuses to participate in any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care.¹³

B. Employee Defined § 741?

Employee is defined as any person who performs health care services for and under the control and direction of any public or private employer which provides health care services for wages or other remuneration.¹⁴

C. Employee Reporting Obligation

Before an employee can seek protection under Labor Law § 741, the employee must have brought the improper quality of patient care to the attention of a supervisor of the employer and afforded such an employer a reasonable opportunity to correct such activity, policy or practice. However, the employee reporting obligation shall not apply if the

¹¹ N.Y. Labor Law §§ 740(4)(a), 740(5).

¹² See N.Y. Labor Law § 740(4)(c).

¹³ N.Y. Labor Law § 741(2); see also N.Y. Labor Law § 741(1)(b).

¹⁴ N.Y. Labor Law § 741(1)(a).

improper quality of patient care presents an imminent threat to public health or safety or to the health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.¹⁵

D. Legal Remedies

Section 741 permits an employee to file a suit seeking, among other things, reinstatement to the same or equivalent position, reinstatement of seniority rights, compensation for lost wages or benefits, recoupment of reasonable costs, and attorney’s fees.¹⁶

E. Employer Defense

It is a defense to an action brought by an employee if the personnel action was based upon grounds other than the employee’s exercise of any rights protected under § 741. For example, it is a defense if the employer can establish the termination was related to work performance.¹⁷

VII. Federal and Additional State Whistleblower Protection Laws

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

The Federal False Claims Act (the “Act”) provides protection to employees, contractors, or agents 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 lawful acts done in furtherance of an action under the Act or other efforts to stop violations of the Act.¹⁸ Remedies include reinstatement with the same seniority as the employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney’s fees.¹⁹

B. New York State False Claims Act (State Finance Law §191)

The New York State False Claims Act (the “State Act”) also provides protection to current or former employees, contractors, or agents of a private or public employer who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment, or otherwise harmed or penalized by an employer or prospective employer, as a result of lawful acts in furtherance of an action under the State Act or other efforts to stop violations of the State

¹⁵ N.Y. Labor Law § 741(3).

¹⁶ N.Y. Labor Law §§ 740(4)(d), (5), 741 (4).

¹⁷ See N.Y. Labor Law § 741(5).

¹⁸ 31 U.S.C. § 3730(h)(1).

¹⁹ 31 U.S.C. § 3730(h)(2).

Act. Remedies include reinstatement to the position such person would have had but for the discrimination or to an equivalent position, two times the amount of back pay, interest on back pay, and compensation for any special damages sustained as a result, including litigation costs and reasonable attorney's fees.²⁰

VIII. Chart Summarizing and Comparing New York Labor Law §§ 740 and 741

Annexed hereto as Attachment "A" is a chart that summarizes and compares the major provisions of New York Labor Law §§ 740 & 741. The chart is designed as a quick reference tool for Workforce Members or other individuals or entities that are under contract, affiliation or have established any other agreement with the NYC Health + Hospitals to familiarize themselves to these two important State anti-retaliation laws.

²⁰ N. Y. Finance Law § 191(1).

ATTACHMENT A

SUMMARY AND COMPARISON OF NEW YORK LABOR LAW §§ 740 AND 741

	N.Y. LABOR LAW § 740 <i>Retaliatory Action By Any Employer</i>	N.Y. LABOR LAW § 741 <i>Retaliatory Action By Health Care Employer</i>
Protected Employee Actions	<p>Prohibits retaliatory personnel action <i>by any employer</i>.</p> <p>An employer shall not take any retaliatory personnel action against an employee because such employee does any of the following protected activities:</p> <ul style="list-style-type: none"> (a) Discloses, or threatens to disclose, to a supervisor or public body an activity, policy or practice of the employer that is in violation of the law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud. (b) Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or (c) Objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation. <p style="text-align: right;">(N.Y. Labor Law § 740(1)(b) and (2))</p>	<p>Prohibits retaliatory action <i>by health care employers</i>.</p> <p>Notwithstanding any other provision of law, no health care employer shall take a retaliatory action against any employee because the employee does any of the following activities:</p> <ul style="list-style-type: none"> (a) Discloses or threatens to disclose to a supervisor, or to a public body, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care; or (b) Objects to, or refuses to participate in any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care. <p style="text-align: right;">(N.Y. Labor Law § 741(1)(b) and (2))</p>
Employee Defined	<p>Employee means an individual who performs services for and under the control and direction of an employer for wages or other remuneration.</p> <p style="text-align: right;">(N.Y. Labor Law § 740(1)(a))</p>	<p>Employee means any person who performs health care services for and under the control and direction of any public or private employer which provides health care services for wages or other remuneration.</p> <p style="text-align: right;">(N.Y. Labor Law § 741(1)(a))</p>
Retaliation Defined	<p>Retaliatory personnel action means the discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.</p> <p style="text-align: right;">(N.Y. Labor Law § 740 (1)(e))</p>	<p>Retaliatory action is the discharge, suspension, demotion, penalization or discrimination against an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.</p> <p style="text-align: right;">(N.Y. Labor Law § 741 (1)(f))</p>

	N.Y. LABOR LAW § 740 <i>Retaliatory Action By Any Employer</i>	N.Y. LABOR LAW § 741 <i>Retaliatory Action By Health Care Employer</i>
Employee Obligations	<p>The employee must bring the activity, policy or practice in violation of law, rule or regulation to the attention of a supervisor of the employer and afford such employer a reasonable opportunity to correct such activity, policy, or practice.</p> <p>(N.Y. Labor Law § 740 (3))</p>	<p>The employee must bring the improper quality of patient care to the attention of a supervisor and afford the employer a reasonable opportunity to correct such activity, policy or practice; <u>UNLESS</u> the improper quality of patient care issue reported by such employee presents an imminent threat to public health or safety or to the health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.</p> <p>(N.Y. Labor Law § 741 (3))</p>
Remedies	<p>Permits an employee to institute a civil action in a court of competent jurisdiction within one year after the alleged retaliatory personnel action was taken. An employee may seek, among other things, injunctive relief, reinstatement to the same or equivalent position, reinstatement of seniority rights, compensation for lost wages or benefits, recoupment of reasonable costs, and attorney’s fees.</p> <p>(N.Y. Labor Law §§ 740 (4)(a), 740(5))</p>	<p>Permits an employee to institute a civil action in a court of competent jurisdiction within two years after the alleged retaliatory action was taken. An employee may seek, among other things, injunctive relief, reinstatement to the same or equivalent position, reinstatement of seniority rights, compensation for lost wages or benefits, recoupment of reasonable costs, and attorney’s fees.</p> <p>(N.Y. Labor Law §§ 740(4)(d), (5), 741 (4))</p>
Employer Defenses	<p>Employers have a defense to a court action if the personnel action was predicated upon grounds other than the employee’s exercise of any rights protected under this law.</p> <p>(N.Y. Labor Law § 740 (4) (c))</p>	<p>Employers have a defense to a court action if the personnel action was predicated upon grounds other than the employee’s exercise of any rights protected under this law.</p> <p>(N.Y. Labor Law § 741(5))</p>

*This chart and above Overview is for illustrative purposes only and shall not be construed as legal advice and is not a substitute for: (i) consulting the actual provisions of these laws in their full statutory form; and (ii) understanding how the judiciary has interpreted and applied these laws. Hence, if you have questions about these important State anti-retaliation statutes, please do not hesitate to contact the Office of Corporate Compliance for further clarification.