



AUDIT COMMITTEE  
MEETING AGENDA

December 7, 2017

11:00 A.M.

125 Worth Street,  
Rm. 532  
5<sup>th</sup> Floor Board Room

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CALL TO ORDER

- Adoption of Minutes October 25, 2017

Ms. Emily A. Youssouf

INFORMATION ITEMS

- Internal Audits Update
- Operating Procedure 50-1 (Corporate Compliance Program)
- Compliance Update

Mr. Chris Telano

Mr. Wayne McNulty

Mr. Wayne McNulty

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT



## MINUTES

### AUDIT COMMITTEE

MEETING DATE: October 25, 2017  
TIME: 9:00 PM

#### COMMITTEE MEMBERS

Emily Youssouf, Committee Chair  
Stanley Brezenoff  
Josephine Bolus, RN  
Mark Page

#### STAFF ATTENDEES

Salvatore J. Russo, General Counsel, Legal Affairs  
Colicia Hercules, Chief of Staff, Chairman's Office  
Patricia Lockhart, Secretary to the Corporation, Chairman's Office  
Arnold Saperstein, Chief Executive Office/MetroPlus  
PV Anantharam, Senior Vice President/Corporate Chief Financial Officer  
Rosa Colon-Colacko, Senior Vice President/Chief People Officer  
Ana Marengo, Senior Vice President/Communications & Marketing  
Jay Weinman, Corporate Comptroller  
Wayne A. McNulty, Corporate Compliance Officer/Senior Assistant Vice President  
Christopher A. Telano, Chief Internal Auditor/Senior Assistant Vice President  
James Linhart, Deputy Corporate Comptroller/Central Office Finance  
Jozef Dubroja, Director/Central Office Finance  
L.R. Tulloch, Senior Director, Office of Facilities Development  
Jose Santiago, Controller, MetroPlus  
Carlotta Duran, Assistant Director, Office of Internal Audits  
Edie Colman, Controller, NYC H + H/Metropolitan

#### OTHER ATTENDEES

KPMG: Maria Tiso, Lead Engagement; Mike Breen, Engagement Partner; Joe Bukzin, Senior Manager; James Martell, Health Resource Partner

**OCTOBER 25, 2017  
AUDIT COMMITTEE MEETING  
MINUTES**

An Audit Committee meeting was held on Wednesday, October 25, 2017. The meeting was called to order at 9:03 A.M. by Ms. Emily Youssouf, Audit Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee meeting held on September 13, 2017. A motion was made and seconded with all in favor to adopt the minutes. An additional motion was made and seconded to hold an Executive Session of the Audit Committee.

Ms. Youssouf introduced the information item regarding the Fiscal Year 2017 Draft Financial Statements and Related Notes.

Mr. PV Anantharam, Senior Vice President, Finance, stated that KPMG is here having done a review of our financial statements for 2017 and will make their presentation to the Audit Committee. Prior to that Jay Weinman will give an overview of our performance in 2017.

Mr. Anantharam added that I want to thank Jay Weinman and his team who do an exemplary job every year. I think I am going to get better next year in terms of timing and other obstacles. This year it was the ERP, last year it was the lack of a comptroller, but his team has done a yeoman's job putting all the documents together. In addition there was GASB 75. I also want to thank Maria Tiso for her last year in this engagement.

Mr. Weinman, Corporate Comptroller, saluted everyone and reported that:

- KPMG has completed the audit of the 2017 System's financials and will be issuing an unmodified opinion, and just like in other years the unmodified opinion states the financial statements are reported fairly in all material aspects.
- On Health and Hospitals implementing of GASB 75, that's the Governmental Accounting Standard Board for OPEB, that's Other Than Pension Employment benefits, that is required a restatement, of the 2016 statement, and that is reflected in these as well.
- Overall, the Hospital's net loss for the year was \$233 million and MetroPlus's gain was \$40, so that's a total of \$193 million on a consolidated basis.

In statements, MetroPlus is reported as a discrete component unit just as we are for the City, and any intercompany transactions are eliminated as part of it.

A couple financial ratios that are important. One is the current ratio for '17 was .90, similar to last year, and the New York State average is just over 1.21, but we are fairly well-positioned in liquidity. Days cash-on-hand was 30. Net days revenue in patients accounts receivable is 53, and that's a reduction from 66 of last year.

Moving on to the financial statements, we will start with the income variances.

Income Statement  
(Statement of Revenues, Expenses and Changes in Net Position)

Operating Revenue

- A. Net patient service revenue – Net patient service revenue decreased by \$201 million as a result of a 3% decrease in DSH revenue. DSH revenue in 2016 included \$277 million for prior years, which is non-recurrent in 2017.
- B. Appropriations from the City of New York – Appropriations from the City was \$723 million, and reflects a decrease from the prior year. The changes are due to an increase to the 2016 subsidies that were originally planned for 2017. The City's assistance to the System is reflected in different places and depends on the kind of assistance they provide. The local shares of DSH and UPLs are reflected in patient care revenue and some others are reflected in the Grants section. Overall, the City's financial assistance to the System has increased substantially.
- C. Grants revenue – increased \$502 million due to additional grant funding consisting of city and federal funds for:
  - \$140 million DSRIP (\$74 million to \$214 million)
  - VBP/QIP - \$240 million
  - CREPS \$163 million

Mr. Anantharam stated that you may recall that we had a significant effort in trying to garner more federal dollars, and the City put up the local share for these grants, so it was a big boost in 2017.

Operating Expenses

- D. Personal services – remained relatively flat from year to year with a slight decrease of \$1 million. This is due to head count (full-time equivalents/employees) control efforts. PS has increased over the past 3 years by 4.5% on average.
- E. Other than personal services – increased \$89 million or 5% and remains consistent with increases from previous years. (Note: The increase from 2015 to 2016, increased \$192 million or 12%.)
- F. Pension – decreased \$76 million as calculated by the New York City Office of the Actuary.
- G. Postemployment benefits, other than pension (OPEB) – decreased \$159 million as calculated by the New York City Office of the Actuary and reflects the amortization of any changes in actuarial assumptions. The 2016 expenses have been adjusted retroactively and restated in these statements.
- H. Operating (loss) income - 2017 is a loss of \$273 million compared to \$19 million.
- I. Increase (Decrease in Net Position) - Health + Hospitals had a decrease in Net Position of \$233 million as compared to an increase in Net Position of \$57 million in 2016.

MetroPlus  
Operating Revenue

AA Premium Revenue – increased \$238 million (8.5%). About half of the increase is due to an increase in member months (5.8 million to 6.1 million) and half due to premium rate increases.

Operating Expenses

BB Other than personal services - increased \$169 million (6.2%), primarily due to an increase in its members.

Balance Sheet (Statement of Net Position)

The balance sheet represents a statement of our worth at a point in time as of June 30 and is a summary of our assets and liabilities

Assets

- A. Cash and Cash Equivalents – Health + Hospitals ended the year with a balance of \$610 million or 30 days cash on hand.
- B. Patient accounts receivable, net – decreased \$99.4 million and 9 days due to additional reserves for long-term in-house patients (\$36 million), and the impact of reduced inpatient discharges of 2.6%.

Liabilities

On the liabilities, not much had changed in terms of our presentation, but we did change the sick leave accruals and the vacation accruals to reclassify a portion of that to long term. This is consistent with accounting principles. We haven't done it in the past, but we did implement it this year, so there is a change, and in between short-term and long-term it hasn't changed all that much, but in the presentation on the balance sheet it has.

- C. Accrued salaries, fringe benefits, and payroll taxes – decreased \$34 million and is consistent with 2016, however a portion of the annual and sick leave accrual has been reclassified to long-term based on generally accepted accounting principles.

Mr. Anantharam added that that is primarily a reflection of when people use their time and leave balances. Generally they have a lot of accrued time, and what is reflected is only that amount that is used up.

Mr. Weinman stated that it also helps on a liquidity basis, anything we move to long-term helps on liquidity analysis. He then announced that that concludes my presentation and asked if there are questions.

Mrs. Bolus asked if you can explain B to me again?

Mr. Anantharam answered that the appropriations from the City of New York. The City of New York gives us approximately \$2 billion of assistance on an annual basis, and that increased significantly over since 2011, and a lot of it is a modulation of how well we have done in terms of our own businesses, so they provide the necessary service for us to close the year. They do it in multiple ways, they provide for the local share of the additional UPL supplemental

payments that we get. They also give us clean subsidies to cover our collective bargaining expenditures and any other needs that we have. They provide the local share for the VBP grants, CREPS grants, and they recently also forgiven us our debt service obligations going forward. This is a reflection of how things are presented in the fiscal statements. The money, even though they are received on a cash basis for our operating costs are for example obligations that we had in prior years, so even though we received the money in '17, we reflect that in '16. The one major reason for the big variance between '16 and '17 was the fact that subsidies that we expected to get in '17 they decided to give us in '16, so that has the effect of inflating the amount regarding '16 and deflating the amount regarding '17. It was the City's actions that caused that to happen, and the reason they did that was they had resources at the time and we had needs at the time. We also needed to shore up our cash balances for the end of the year. As Jay Weinman pointed out, the cash on hand at the end of the year, last year, this closing was \$600 million. A big part of that was the fact that they gave us those moneys earlier.

Mr. Page commented that that has something to do with the City managing its own surplus at yearend. When the City is looking to park money, they can do it by giving it to us early.

Mrs. Bolus asked does that count against us next year? To which Mr. Anantharam responded that we have the cash on hand, so our performance during the year will tell us how much.

Mr. Page added that in theory, it gives us the cash so that they don't need to give us that amount of cash in the next period the next year. It's accelerating what they would think they were going to give us in the next year.

Mr. Anantharam added that as Mr. Page points out, it is also a cash management on their part, on their side of the ledger.

Mr. Page asked why did pensions and OPEB go down suddenly?

Mr. Weinman responded that part of it has to do with the investment earnings, and also with the new GASB. Part of the changes of estimates are spread over seven years instead of immediately taken in the current year. What normally would have appeared as an expense is allocated and amortized over the future.

Mr. Page stated so they pushed the cost up. Mr. Weinman replied yes.

Mr. Page added that someday I would love to see what we count as a City subsidy to us and what payments by the City we don't count. The City share of Medicaid for instance we don't count, but it seems that other matching amounts of City and federal, some of it can we do count, and this is probably not the moment, but at some point I would be interested in knowing that.

Mr. Anantharam commented that we have a document we can provide and go over. We did a presentation in the financial statements that reflect those funding in budgets.

Ms. Youssouf said that if we do that, we also shouldn't include anything the State gives us in there.

Mr. Anantharam stated that what we have done is a presentation of our entire financial plan by source of funding. The City tends to be the largest amount. The federal government tends to be the one following, and the State government's contributions are on the lower end of the spectrum.

Mr. Campbell stated that maybe we could have that at the upcoming Finance meeting. As I look around the table, all the Board members on this Committee are on the Finance Committee.

Ms. Youssouf asked if there were any other questions? If not I would like to thank, PV Anantharam and Jay Weinman, I'm glad we are following this format that we established last year because it makes it much easier for all of the Committee members to actually pinpoint, and I know we spend a lot of time going through, but thank you very much.

Ms. Youssouf then stated that right now we have to do something a little differently because Stan Brezenoff has a commitment, so I'm going to ask for an executive session now to discuss potential liabilities and litigation, so if I could ask everyone except the Board and who has to stay please leave, and then we are going to reconvene the public session.

Mr. Russo asked Madam Chair, can we accept the financial report. The financial report was unanimously accepted by the Committee.

Ms. Youssouf said that during executive session, we discussed a matter related to potential litigation. Executive session is over – I would like to continue with the main meeting.

Ms. Maria Tiso, KPMG Engagement Partner, introduced the audit team members consisting of Mike Breen, Engagement Partner; Joe Bukzin, Engagement Senior Manager and Jim Martel, Healthcare Resource Partner.

Ms. Tiso stated that what we're going to discuss with you is our 2017 required communications as it relates to the June 30th audit of H + H. I'll walk you through the deliverables, our required communications, and our next steps. There's still some items that need to be completed before we issue financial statements.

The deliverables that we will be issuing are consistent to what we discussed during the audit plan in June. We will be issuing the NYC H+H financial statements, our debt compliance letter and our required communications, which we are discussing today.

Other deliverables we issue in September, the completeness and accuracy census data attestation, which is done every three years, and it's requested by the City pension plan auditors, so that's already been issued.

We will be issuing the management letter. We will be coming to this Committee in mid-December, I'm not sure if that date has been scheduled at the time.

We will also be issuing various regulatory cost reports, the MetroPlus Health Plan financial statements, which is due in March, the HHC Insurance Company and the HHC HCO. All of those will be expected to be issued in 2018.

As Jay Weinman had mentioned, we will be issuing an unmodified auditor's report, which is the highest level of assurance that the financial statements are free of material misstatements. There is one emphasis of matter

paragraph included in our opinion, and what that does is highlight to the reader of the financial statement that there was something significant that was disclosed in the financial statements, and as Jay Weinman indicated there was a new accounting standard GASB 75, accounting and financial reporting of post-employment benefits, so that's been appropriately disclosed and reflected in the financial statement during the current year.

I'm going to turn it over to Joe Bukzin, he will walk you through some of the significant audit areas and accounting estimates that we worked on during the audit.

Mr. Joe Bukzin said that just to lead things off, this is consistent with our audit approach and what we had presented back during planning in terms of the significant estimates and audit areas that we're focused on, so I'll just take the Committee through some of the highlights.

The first item, evaluation of hospital patient accounts receivable, we spend time first understanding and evaluating management's process. You might recall last year we did have some observations from management to improve and enhance that process. They made some changes. We spent some additional effort and time reviewing their process as well as doing our own independent analysis, which looks at historical collections as well as projections. Mike Breen will touch upon one adjustment that resulted from the review of that area.

In terms of the evaluation of third-party receivables and liabilities, we did focused on UPL, Dish and iPro. One of the highlights is around the collectability of DSH. Many of us were aware of what was reported, and we focused on that as part of our audit effort including receiving the correspondence that was provided by the State related to the expected payout over the next few months between now and the end of the year.

The next several items deal with the claims liability as well as pension and other post-retirement. Those are actuarially determined estimates. As part of our audit process, we do involve an actuary to assist us in reviewing the key assumptions and inputs that go into those estimates, and all the balances are fairly and reasonably stated in the financial statements.

We explained to the Committee our focus over liquidity, and we wanted to circle back and highlight for the Committee what some of those considerations were. I won't read through all of them, but we did look at certain financial metrics, but we also placed a lot of weight on the relationship that H+H has with the City, one with the appropriations that have been received over the course of time, their flexibility with certain obligations in time and payments as well as some of the additional funding with respect to grants and really the focus and the importance of the Corporation to the community it serves. That's one of the main missions of the organization. The relationship the City has with the Corporation is an important one.

We did not identify significant risk related to going concern. I would also like to mention that Jay Weinman, PV Anantharam and their team did go through an exercise of documenting their position as well, which covered many of these points.

Ms. Youssef asked what do you mean documenting their position?



Ms. Tiso replied that as it relates to liquidity, when we came to you in June, we determined that liquidity could be a potential significant risk. We look at it two ways, we look at the March internal financial statements, and obviously when you look at those financial statements, there are a lot of adjustments that haven't been posted, your actuary adjustments, and some of the appropriations from the City. A lot of that happens in the fourth quarter, then we look at it after all the adjustments are posted. In the interim because it was significant during interim and in accordance with the GASB management has to assess is the entity a going concern, so it's really management's responsibility to lay out a plan and document what is going on with the Mayor's Transformation Plan. They sent several reiterations going through the budget, financial forecasts and were very helpful in helping us get to the conclusion and numerous conversations with Sal Russo also that as of June 30th liquidity is not a significant risk. I must tell you the issue with the DSH receivables was an issue because we had to evaluate the collectability of the receivables. There's never been a time when that payment hasn't been received by the time the financial statement was issued. There were a lot of items that we discussed between KPMG and the management team, and they were very, very helpful with that.

Mr. Bukzin continued and said that just some other notable transactions. I won't go through every one, Jay Weinman touched upon many of these. Grants revenue increased quite a bit from period to period, and most of that was related to these three particular programs that are well disclosed in the notes and financial statements. On an aggregate level that's approximately \$600 million of additional grant revenue recognized in '17.

Also, we identified the related party transactions as it relates to the appropriations with the City, I'll call it forgiveness or assuming of liability with respect to 2017 debt service that was not required to be paid by H+H.

We also highlight some of our risk-assessment procedures with respect to IT controls, and we'll plan to circle back to the Committee on our observations as part of our management letter process.

Mr. Breen reported on a couple of other required communications. I'll highlight some of the others we have here. First from an accounting policy perspective it is laid out in footnote one of the financial statement. It is consistent with what they have been in the past. The differences are three new accounting standards. I think we spent time talking about that GASB 75, post-employment benefits. That's probably the biggest change this year. I know that Maria Tiso mentioned that we'll be coming back with the management letter. There were no material weaknesses identified as a result of our audit.

We want to confirm our independence from H+H as well as folks in the financial reporting roles. We are not aware of any relationships that would cause concern for our independence.

I also want to talk about illegal acts of fraud, something we had talked about in our planning meeting, and we had inquiries with senior management and legal counsel. We involved a forensic professional as well as a professional practice partner in some of that discussion. We are not aware of anything that would be material to the financial statements.

The three recorded adjustments that affect the statement of revenue expenses and change in net position were all impacting receivables that were recorded. Evaluation of patient AR was actually an increase in receivable, grants was a reduction in receivable, and on MetroPlus there was an adjustment to the stop loss receivable. Each of those impacted the statement of revenue expenses, and basically I would say we were challenging the assumptions that were made in many cases based on cash selections, and as a result those adjustments were recorded during the audit.

There were some reclassifications on the statement of financial position. I think Jay Weinman highlighted the largest one, which would be accrued sick time and accrued holiday time. That actually got downward classified into current versus long term based on the expected payout. We thought that was reasonably stated.

The City expects issuance of the financial statements by tomorrow. Our plan is to issue either later today or by tomorrow morning once we wrap up these open items here, which is management's signing the rough letter and us doing our subsequent events review to make sure there's nothing else to be disclosed in the financial statements.

Ms. Tiso stated that that concludes our presentation.

Ms. Youssof asked if there any questions? Then said thank you very much for your hard work. You guys have been really cooperative and again I'd like to thank PV Anantharam and Jay Weinman for all their hard work making a really good presentation and dealing with these very difficult times financially for us.

There being no other business, the meeting was adjourned at 10:02 A.M.

Submitted by,

Ms. Emily Youssof  
Audit Committee Chair

# **AUDIT COMMITTEE OF THE NYC HEALTH + HOSPITALS BOARD OF DIRECTORS**

## **Overview of Operating Procedure 50-1 *Corporate Compliance and Ethics Program***

**Corporate Compliance Report  
December 7, 2017**



**Background and Summary of Revised Operating Procedure 50-1:  
Corporate Compliance and Ethics Program**

**I. Introduction**

1. It is the Policy of the NYC Health + Hospitals (the “System”) to establish, monitor, and maintain an effective Compliance and Ethics Program centered on:
  - 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”) laws<sup>1</sup>; and (ii) represents the System’s commitment to maintain its status as a reliable, honest, and trustworthy healthcare provider;<sup>2</sup>
  - Identifying and eliminating fraud, waste and abuse;
  - Assessing, prioritizing and mitigating System-wide risks; and
  - Promoting and fostering a climate of ethical conduct and good governance.
2. The aforementioned policy goals are accomplished, in pertinent part, by the establishment and implementation of an effective compliance program, which is governed under System Operating Procedure 50-1 – *Corporate Compliance Program* (“OP 50-1”). OP 50-1 was established to meet certain legal requirements, which are detailed below in section II. OP 50-1 was originally promulgated by System in 2009, and subsequently amended in 2010, to add a Disciplinary Policy and Revised Non-Retaliation section.
3. The Office of Corporate Compliance (“OCC”) has revised the existing OP 50-1 to:
  - Meet current regulatory standards, implementing guidelines, and best compliance program practices; and
  - Outline the expanded scope of the System’s compliance program. The key highlights to the revised OP - - now titled *Corporate Compliance and Ethics Program* (the “Program”) - - are provided in the paragraphs that follow.

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<sup>1</sup> For purposes of this OP: (i) New York State law includes applicable local law; and (ii) the term “laws” collectively includes all applicable Federal and State laws, codes, rules, and regulations.

<sup>2</sup> See, generally, 63 Fed. Reg. 8987, 8995 (1998), § [II][E][1].

## **II. Legal Requirements**

### **A. Social Services Law 363-d & 18 NYCRR Part 521**

1. Pursuant to Social Services Law § 363-d and its implementing mandatory provider compliance program regulations found at 18 NYCRR Part 521, the System is required, as a condition of participation in the Medicaid program, to implement an effective compliance program. In order to satisfy this requirement, there are specific compliance program elements that must be met by the System including, without limitation, the establishment of written policies and procedures that:<sup>3</sup>

- Describe compliance expectations;
- Implement the operation of the compliance program;
- Provide guidance to Covered Persons (*e.g.*, Workforce Members, Business Partners, and Agents) 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.

### **B. Regulatory Oversight Agency Guidance and Federal Sentencing Commission Guidelines**

*U. S. Department of Health and Human Services Office of Inspector General Compliance Program Guidance for Hospitals* (1998) and *OIG Supplemental Compliance Program Guidance for Hospitals* (2005)

2. Like Part 521, guidance issued by the Office of Inspector General of the U.S. Department of Health and Human Services (“OIG”) provides that compliance programs, such as the Program operated by the System, “should require the development and distribution of written compliance policies that identify specific areas of risk to the hospital.”<sup>4</sup> Such policies shall “establish bright-line rules that help employees carryout their job functions in a manner that ensures compliance with Federal healthcare program [and private payor] requirements and furthers the mission and objective of the hospital

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<sup>3</sup>18 NYCRR 521.3(c)(1)

<sup>4</sup>U.S. Department of Health and Human Services Office of Inspector General (“OIG”), *Publication of the OIG Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 8987, 8989, § [II][A] (1998), accessed at <http://oig.hhs.gov/authorities/docs/cpghosp.pdf>

itself.”<sup>5</sup>

C. United States Sentencing Commission Guidelines Manual

3. Similar to Part 521 and OIG Guidance, in order to meet elements of an effective Manual, organizations like the compliance program under the 2016 United States Sentencing Commission Guidelines System must establish standards and procedures “to prevent and detect criminal conduct.”<sup>6</sup>

**III. New and Expanded Areas Covered in the Revised OP 50-1**

1. In a nutshell, the updated OP 50-1 provides:
  - Definitions of key Program terms such as Compliance; Ethics; Fraud; Waste; Abuse; and Retaliation;
  - An outline of the key policy terms and Program focus;
  - Clarification of the Program’s scope and applicability to cover all Workforce Members, Business Partners, and Agents (collectively “Covered Persons” at each System unit, facility and entity);
  - The mandate that all Covered Persons affirmatively participate in the Program by, at the minimum, complying with the following requirements:
    - Adhering to compliance standards including applicable Federal and State law;
    - Committing to ethical conduct;
    - Adhering to standards of conduct;
    - Refraining from engaging in retaliatory conduct;
    - Refraining from engaging in wrongdoing;
    - Reporting compliance issues and concerns; and

<sup>5</sup> U.S. Department of Health and Human Services Office of Inspector General (“OIG”), *Publication of the OIG Compliance Program Guidance for Hospitals*, 70 Fed. Reg. 4858, 4875, § [II][B] [2] (2005), accessed at <https://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>

<sup>6</sup> 2016 United States Sentencing Commission Guidelines §8B2.1 (b)(1)

- Protecting the privacy and security of confidential information.
- An outline of the different compliance program requirements - - based on provider type and risk area - - under applicable Federal and State law and regulatory/oversight agency guidance;
- A more detailed Disciplinary Policy that outlines sanctions for Covered Persons who fail to affirmatively participate in the Program;
- The inclusion of an expanded overview of the System’s whistleblower protection policy including an attachment that provides an educational overview of NY Labor Law §§ 740 and 741; and
- The inclusion of numerous attachments to assist Covered Persons to better understand their compliance obligations under OP 50-1. The attachments provide a summary of some of the key points of the OP, and function 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;
  - Ensure that certain documents that are referenced in the OP are easily available in their entirety for Cover Persons to review; and
  - Further inform and educate Covered Persons on the fine nuances and various requirements the System must meet to maintain an effective compliance program.

**IV. Summary of the Responsibilities of Covered Persons**

1. The responsibilities of Covered Persons are outlined in *NYC Health + Hospitals Corporate Compliance and Ethics Program - Summary of Workforce Member, Business Partners, and Agent Responsibilities*, which is annexed hereto as Attachment “A.”

**V. Next Steps**

1. OP 50-1 is in its final state and expected to be approved by President and Chief Executive Officer Stanley Brezenoff in the next 7-10 days. OP 50-1 will be placed on the NYC Health + Hospitals’ public website and internal intranet once approved by the President.

# **ATTACHMENT “A”**



NYC HEALTH + HOSPITALS

**CORPORATE COMPLIANCE AND ETHICS PROGRAM**

***SUMMARY OF WORKFORCE MEMBER, BUSINESS PARTNER, AND AGENT RESPONSIBILITIES<sup>1</sup>***

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 Operating Procedure (“OP”) 50-1 - *Corporate Compliance and Ethics Program* (the “Program”). These are summarized below:

- Adhering to compliance standards, including applicable Federal and State law
- Protecting the privacy and security of confidential information;
- Adhering to standards of conduct;
- Refraining from engaging in retaliatory conduct;
- Committing to ethical conduct;
- Refraining from engaging in wrongdoing or other prohibited activities;
- Reporting compliance issues and concerns; and

Covered Persons who fail to comply may be subject to disciplinary action up to and including termination of employment, contract, or other relationship with the System.

**1. Adherence to Compliance Standards.** 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 Federal and State Law or the System’s internal information governance policies or contractual requirements (e.g., business associate, qualified service organizational 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 legal privileges or applicable laws, 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.<sup>2</sup> 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.

<sup>1</sup> Current as of 12/4/17.

<sup>2</sup> There are additional standards of conduct concerning pharmaceutical company gifts and sponsored educational programs (OP 20-55) and nepotism (OP 20-54), which 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 personnel (e.g., SUNY Downstate, PAGNY, Mt. Sinai, NYU) as well as on affiliate subcontractor personnel who function as contract service providers and support staff at the System. Members of the System’s various Community Advisory Boards and Auxiliaries and other System personnel not covered by Chapter 68 must 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](mailto: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)**

**6. Prohibition of Retaliation / Whistleblower Protection.** 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, or discrimination against any individual or other adverse employment action imposed as a consequence of any individual’s engagement in protected conduct or other participation in the Program.

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

- Participating in the Program in a non-compliant manner by failing to comply with any of the compliance requirements set forth 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;
- 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 merely 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/>.*



**AUDIT COMMITTEE OF THE  
NYC HEALTH + HOSPITALS  
BOARD OF DIRECTORS**

**Corporate Compliance Report  
December 7, 2017**

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**I. National Corporate Compliance and Ethics Week – November 5 -11, 2017 - *Make Good Choices.***

- 1) NYC Health + Hospitals (hereinafter also referred to as the “System”) celebrated its commitment to support an organizational culture that fosters the delivery of healthcare to our patient population in a legally compliant and ethical manner by celebrating National Corporate Compliance and Ethics Week, November 5-11, 2017. This year’s compliance theme is *Make Good Choices*.
- 2) Indeed, NYC Health + Hospitals has made good choices by devoting significant resources to developing an effective Corporate Compliance and Ethics Program by launching continuous efforts to:
  - strive to eliminate fraud, waste, and abuse
  - identify potential areas of system-wide risk;
  - address and resolve incidents of noncompliance and unethical conduct;
  - provide compliance training and education to its workforce members, business partners, and agents; and
  - protect whistleblowers from intimidation or any other form of retaliation.
- 3) During Compliance Week, workforce members were afforded the opportunity to learn more about compliance and ethics at NYC Health + Hospitals. This effort was accomplished by Office of Corporate Compliance’s (“OCC”) proactive outreach at the various System facilities, where compliance staff emphasized to workforce members the importance of them performing their duties and functions in a compliant and ethical. Compliance Week events were held on a daily basis across the System’s acute care, long term care/skilled nursing facilities, ambulatory care facilities, as well as in Central Office and NYC Health + Hospitals/Home Care. Workforce members were greeted by the OCC staff with educational and informational handouts. The OCC is pleased to report that hundreds of workforce members participated in these System-wide events on each day during Compliance Week.
- 4) As part of Compliance Week, all System workforce members, business partners and agents we provided with a copy (through e-mail distribution) of the System’s *Principles of Professional Conduct*, which is a guide that sets forth the System’s compliance expectations and commitment to comply with all applicable Federal and State law.

## **II. Monitoring of Excluded or Sanctioned Providers**

### Overview of Regulatory Requirements

1) Federal regulations prohibit the allocation of Federal health care program (*e.g.*, Medicaid, Medicare) payments “for an item or service furnished ...by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.”<sup>1</sup> Likewise, New York State (“NYS” or the “State”) has promulgated billing prohibitions related to services furnished by an excluded provider. Lastly, to maintain an active enrollment status in the Medicare program, the System must certify that it does not employ or contract with individuals or entities that are “excluded from participation in any Federal health care programs for the provision of items and services covered under the programs.”<sup>2</sup>

### Responsibilities of the System for Sanction List Screening

2) To adhere to these regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General (“OMIG”)<sup>3</sup> and the United States Department of Health and Human Services Office of the Inspector General (“OIG”), each month the Office of Corporate Compliance (“OCC”) reviews the exclusion status of NYC Health + Hospital workforce (*e.g.*, employees, board members, affiliates, personnel, volunteers and medical staff members), vendors and DSRIP partners.

### Office of Foreign Asset Control (“OFAC”) Screening

3) To ensure that the System does not conduct business with individuals or entities that are a threat to the security, economy or foreign policy of the United States, the OCC also screens all NYC Health + Hospital workforce members, vendors and DSRIP partners against the databases of the United States Department of Treasury Office of Foreign Asset Control (“OFAC”).<sup>4</sup>

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<sup>1</sup> Scope and Effect of Exclusion 42 CFR § 1001.1901 (b); *see also* 42 CFR § 1002 (the authority of State agencies to exclude on their own initiative, regardless of whether the OIG has excluded an individual or entity).

<sup>2</sup> *See* 42 CFR § 424.516 (a) (3); *see also* 42 CFR § 424.535(a) (2) (regarding CMS’ option to revoke enrollment and billing privileges due to exclusion from Medicare, Medicaid or any federal program). *See also* 42 USC 1320c-5 (Regarding obligations of health care practitioners and providers and the Secretary of Health and Human Services’ right to exclude a person or entity for failing to meet the obligations.)

<sup>3</sup> DOH Medicaid Update April 2010, Vol.26, No. 6 and the NY OMIG webinar #22 OMIG Exclusion and Reinstatement Process, <https://omig.ny.gov/resources/webinars/811-omig-webinar-22> [Slide 20 (Sept 2014), accessed Nov. 29, 2017.]

<sup>4</sup> *See* Frequently Asked Questions: Who must comply with OFAC regulations? United States Treasury website, [https://www.treasury.gov/resource-center/faqs/Sanctions/Pages/faq\\_general.aspx](https://www.treasury.gov/resource-center/faqs/Sanctions/Pages/faq_general.aspx) [accessed Nov. 29, 2017.]

Exclusion and Sanction Screening Report August 31, 2017 through November 29, 2017

4) Since the OCC last reported excluded provider activities at the September 13, 2107 Audit Committee, one (1) excluded provider and three (3) suspended providers were identified.

5) On September 19, 2017, OCC was informed that a physician on NYC Health + Hospitals' list of community physicians, who referred patients to NYC Health + Hospitals' / At Home, is excluded by OMIG, effective June 21, 2017. This community physician referred a patient through the Telehealth program prior to the physician being excluded. The OCC is not aware of any activity this excluded community physician has had with NYC Health + Hospitals since the effective date of his OMIG exclusion. The OCC is working with At Home to ensure that any future patients referred by this excluded community physician are seen by another physician for any At Home required orders.

Death Master File and National Plan and Provider Enumeration System Screening

6) Center for Medicare and Medicaid regulations<sup>5</sup> and the contractual provisions found in managed care organization ("MCO")<sup>6</sup> provider agreements both require screening of NYC Health + Hospitals workforce members and certain business partners (collectively "Covered Persons") to ensure that none of these Covered Persons are using the social security number ("SSN") or National Practitioner Identification Numbers ("NPI") of a deceased person in an effort to hide their true identity. This screening may be accomplished by vetting the SSNs and

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<sup>5</sup> See CMS's Toolkit to Address Frequent Findings 42 CFR § 455.436 Federal Database Checks, <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf> (accessed Nov. 29, 2017), *see also generally*, 42 CFR § 455.436.

<sup>6</sup> "Provider ... agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES)". New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts, Appendix Revised April 1, 2017, at 4, available at: [https://www.health.ny.gov/health\\_care/managed\\_care/hmoipa/docs/standard\\_clauses\\_revisions.pdf](https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/standard_clauses_revisions.pdf), (accessed Nov. 29, 2017).

NPIs of Covered Persons through the Social Security Administration Death Master File (“DMF”) and the National Plan and Provider Enumeration System (“NPES”), respectively.

7) The OCC currently screens the DMF and NPES files as part of its sanction screening process. There are no providers that have been identified on the DMF since the last time the Audit Committee convened in September 2017.

### **III. Privacy Incidents and Related Reports**

#### Background

1) The Office of HIPAA Privacy and Security within the OCC is responsible for reviewing, investigating, and responding to potential and confirmed breaches of PHI.

#### ***A. Reportable Privacy Incidents for the Second Quarter of Calendar Year 2017 (April 1, 2017 to June 30, 2017 – hereinafter “2nd Quarter”)***

2) During the period of April 1, 2017 through June 30, 2017, twenty-four (24) complaints were entered in the ID Experts RADAR Incident Tracking System. Of the 24 complaints entered in the tracking system, fourteen (14) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures; seven (7) were determined to be unsubstantiated; three (3) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures.

- Of the 13 incidents confirmed as violations, three (3) were determined to be breaches.

#### Breach Defined

3) A breach is an impermissible use, access, acquisition or disclosure (hereinafter collectively referred to as “use and/or disclosure”) under the HIPAA Privacy Rule that compromises the security and privacy of PHI maintained by the Corporation or one of its business associates.<sup>7</sup>

4) Pursuant to 45 CFR § 164.402 [2], the unauthorized access, acquisition, use or disclosure of PHI is presumed to be a breach unless the System can demonstrate that there is a low probability that the PHI has been compromised based on the reasonable results of a thorough risk assessment, that is completed in good faith, of key risk factors.<sup>8</sup>

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<sup>7</sup> 45 CFR § 164.402 [“Breach” defined].

<sup>8</sup> See 45 CFR § 164.402[2]; see also 78 Fed. Register 5565 at 5643 and 5695 [January 25, 2013]



Factors Considered when Determining Whether a Breach has Occurred

5) Under HIPAA regulations, at a minimum the following four key factors must be considered to determine whether there is greater than a low probability that a privacy and/or security incident involving PHI has resulted in the compromise of such PHI:<sup>9</sup>

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed; and
- The extent to which the risk to the protected health information has been mitigated.

Reportable Breaches in the 2nd Quarter

6) As stated above, there were three (3) reportable breaches in the 2nd Quarter. Below is a summary of said breaches:

- **NYC Health + Hospitals /Harlem – April 2017**

**Incident:** The incident was discovered on or about April 17<sup>th</sup> and occurred when two employees accessed the medical record of another employee who was a patient at NYC Health + Hospitals/Harlem (“Harlem”). Both employees and the patient-employee work in the Admitting department at Harlem. The employee/patient is the supervisor of the two employees and was out on medical leave during the time of the unauthorized access. A Harlem workforce member made a complaint regarding the incident. An access audit report was generated for the patient record which confirmed access by the two employees. The information accessed included demographic and treatment information.

**Breach Determination:** Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on June 14, 2017.

**Mitigation:** The two employees were immediately suspended and a formal labor management hearing is ongoing.

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<sup>9</sup> See 45 CFR § 164.402 [2][i-iv].

- **NYC Health + Hospitals /Elmhurst – May 2017**

**Incident:** The incident at hand occurred at NYC Health + Hospitals/Elmhurst (“Elmhurst”). The incident was discovered on or about May 2<sup>nd</sup> and occurred when it was discovered that an employee had accessed the medical record of a patient on multiple occasions. The caregiver of the patient is the neighbor of the employee. The patient had completed an “Authorization to Disclose Health Information” form authorizing the discharge information be disclosed to the employee. However, the authorization did not extend to access of the patient’s medical record. An access audit report showed that the employee had accessed the record on multiple occasions prior to the completion of the authorization to disclose form and after the authorization term limit had expired. The information accessed included general treatment information as well as sensitive information such as mental health information. The employee also attempted to discuss the patient’s treatment with his treating provider but was not authorized to act as his personal representative.

**Breach Determination:** Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on June 29, 2017.

**Mitigation:** A formal labor management hearing occurred where it was recommended that disciplinary action be taken against the employee.

- **NYC Health + Hospitals /Harlem – June 2017**

**Incident:** The subject incident, which occurred at Harlem, involved a physician who discussed the medications of his patient in the presence of a visitor, without the patient’s explicit consent. Upon realizing his mistake, the physician immediately went in and personally apologized to the patient. This was determined to be a HIPAA violation as the physician did not secure the patient’s permission to discuss protected health information in front of the visitor.

**Breach Determination:** Based upon the facts found during the investigation, the incident was determined to be a breach and notification was subsequently sent to the patient.

**Mitigation:** The subject physician was counseled and went through comprehensive HIPAA retraining. Additionally, a HIPAA information session was conducted for all physician house staff where at the “Do’s and Don’ts” of patient confidentiality were reinforced.

OCR Inquiries regarding potential and/or determined Privacy Incidents during the 2<sup>nd</sup> Quarter

7) There were no inquiries initiated by OCR in the second quarter of 2017.

***B. Reportable Privacy Incidents for the Third Quarter of Calendar Year 2017 (July 1, 2017 to Sep 30, 2017 – hereinafter “3rd Quarter”)***

8) During the period of July 1, 2017 through Sep 30, 2017, twenty-one (21) complaints were entered in the ID Experts RADAR Incident Tracking System. Of the 21 complaints entered in the tracking system, eight (8) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy Operating Procedures; eight (8) were determined to be unsubstantiated; three (3) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures; and two (2) are still under investigation.

- Of the 8 incidents confirmed as violations, three (3) were determined to be breaches.

Reportable Breaches in the 3<sup>rd</sup> Quarter

9) As stated above, there were three (3) reportable breaches in the 3rd Quarter. Below is a summary of said breaches:

- **NYC Health + Hospitals/Kings – July 2017**

**Incident:** The incident was discovered on July 18 2017 and had occurred when on March 23rd, 2017, an employee inadvertently posted on her Facebook page, an image which included the PHI of seventeen (17) patients. The PHI was limited to name, date, location and the fact that the patients were scheduled for a bedside blood glucose test.

**Breach Determination:** Based upon the facts found during the investigation, the incident was determined to be a breach. Notifications were sent to the affected individuals on Sep 14, 2017.

**Mitigation:** The post was discovered by another Kings Workforce member and upon discovery, it was promptly taken down and the Facebook account was de-activated. Staff training was conducted to advise them of the risks of social media. The OCC’s investigation of this matter concluded that no other information other than the elements described above was part of the subject impermissible image. The department has recommended disciplinary action for the employee and a formal labor management hearing is pending.

- **NYC Health + Hospitals/Jacobi – September 2017**

**Incident:** The incident occurred on September 16<sup>th</sup> when a nurse disclosed PHI to a visitor of the patient, wrongly assuming that the visitor was aware of the patient's condition. The PHI disclosed included information such as the medications for the treatment of a sensitive health condition.

**Breach Determination:** Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on Oct 24, 2017.

**Mitigation:** The nurse has been counseled and completed a comprehensive in-person HIPAA training course.

- **NYC Health + Hospitals/Metropolitan – September 2017**

**Incident:** The incident, which occurred at NYC Health + Hospitals/Metropolitan ("Metropolitan"), was discovered on September 18<sup>th</sup> and occurred when a technician performed an electroencephalogram ("EEG") test on three patients. Although the test was medically necessary and the technician was supervised by medical personnel, the technician had not been adequately processed through Metropolitan's Human Resources ("HR") department.

**Breach Determination:** Based upon the facts found during the investigation, the incident was determined to be a breach. Notifications were sent to the affected individuals on November 17, 2017.

**Mitigation:** The subject Director has been counseled and mandated to complete additional HIPAA training.

OCR Inquiries regarding potential and/or determined Privacy Incidents

10) There were no inquiries initiated by OCR in the 3<sup>rd</sup> quarter of 2017.

**IV. Compliance Reports - Third Quarter and Fourth Quarter Reports to Date**

**A. Summary of Third Quarter Report: July 1, 2017 to September 30, 2017**

1) For the third quarter CY2017 (July 1, 2017 to September 30, 2017) there were 86 compliance-based reports of which three (or 3.5 %) were classified as a Priority "A",<sup>10</sup> 35 (or

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<sup>10</sup> There are three (3) different report categories: (i) Priority "A" reports - matters that require immediate review and/or action due to an allegation of immediate threat to a person, property or environment; (ii) Priority "B" reports – matters of a time-sensitive nature that may require prompt review and/or action; and (iii) Priority "C" reports – matters that do not require immediate action.

**OFFICE OF CORPORATE COMPLIANCE**

40.7%) were classified as Priority “B”, and 48 (or 55.8%) were classified as Priority “C” reports. For purposes here, the term “reports” means compliance-based inquiries and compliance-based complaints. Of the 86 reports received during this period, 47 (or 54.7%) were compliance complaints received on the OCC’s anonymous toll-free compliance hotline.

**i) PRIMARY ALLEGATION CLASS**



- CHART DATA	Frequency (Percentage)
Diversity, Equal Opportunity and Respect in the Workplace	8.0 (9.3 %)
Employee Relations	15.0 (17.4 %)
Environmental, Health and Safety	6.0 (7 %)
Financial Concerns	2.0 (2.3 %)
Misuse or Misappropriation of Assets or Information	13.0 (15.1 %)
Other	12.0 (14 %)
Policy and Process Integrity	30.0 (34.9 %)
Totals	86.0 (100%)

**ii) PRIMARY ALLEGATION TYPE**

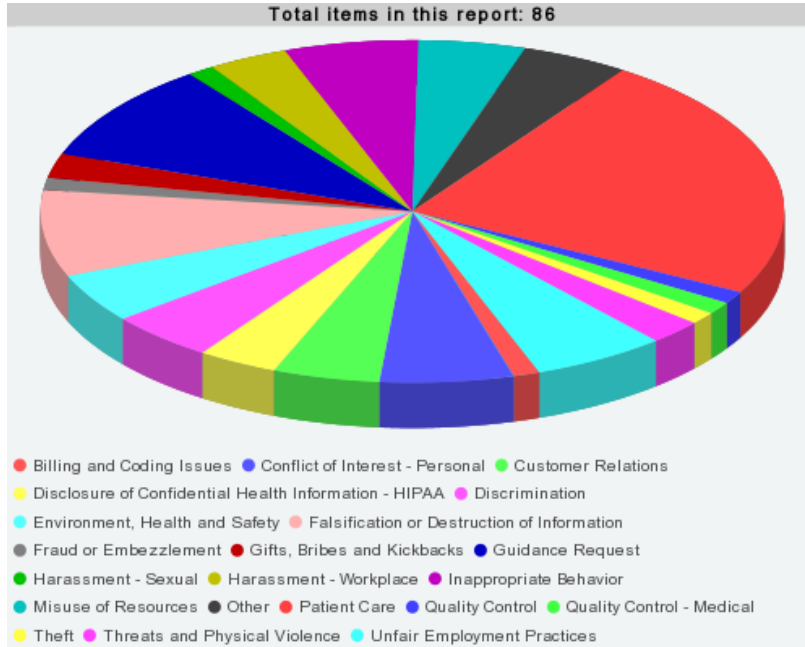
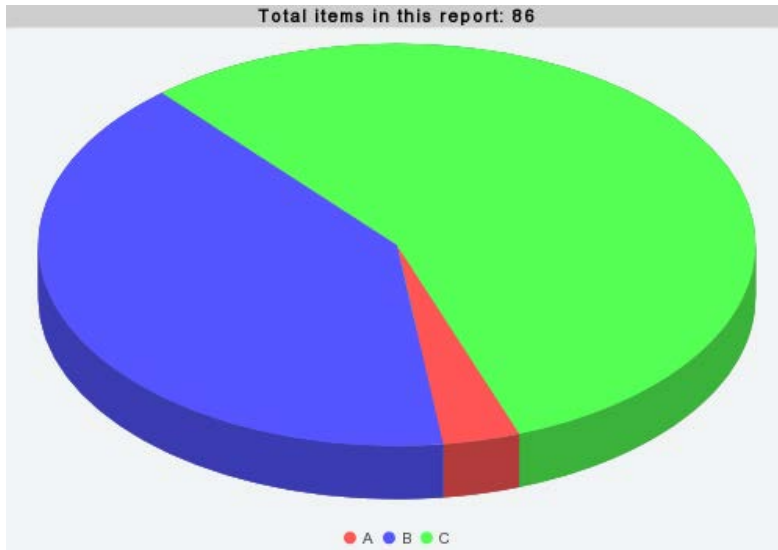


CHART DATA	Frequency (Percentage)
Billing and Coding Issues	1.0 (1.2 %)
Conflict of Interest - Personal	5.0 (5.8 %)
Customer Relations	4.0 (4.7 %)
Disclosure of Confidential Health Information - HIPAA	3.0 (3.5 %)
Discrimination	4.0 (4.7 %)
Environment, Health and Safety	4.0 (4.7 %)
Falsification or Destruction of Information	7.0 (8.1 %)
Fraud or Embezzlement	1.0 (1.2 %)
Gifts, Bribes and Kickbacks	2.0 (2.3 %)
Guidance Request	8.0 (9.3 %)
Harassment - Sexual	1.0 (1.2 %)
Harassment - Workplace	3.0 (3.5 %)
Inappropriate Behavior	5.0 (5.8 %)
Misuse of Resources	4.0 (4.7 %)

**OFFICE OF CORPORATE COMPLIANCE**

Other	4.0 (4.7 %)
Patient Care	20.0 (23.3 %)
Quality Control	1.0 (1.2 %)
Quality Control - Medical	1.0 (1.2 %)
Theft	1.0 (1.2 %)
Threats and Physical Violence	2.0 (2.3 %)
Unfair Employment Practices	5.0 (5.8 %)
Totals	86.0 (100%)

**iii) PRIORITY CLASSIFICATIONS**



<b>CHART DATA</b>	<b>Frequency (Percentage)</b>
A	3.0 (3.5 %)
B	35.0 (40.7 %)
C	48.0 (55.8 %)
Totals	86.0 (100%)

**B. *Fourth Quarter Reports to Date: October 1, 2017 to November 29, 2017***

2) For the period from October 1, 2017 to November 29, 2017 there were 64 compliance-based reports of which one (or 1.6%) was classified as a Priority “A”,<sup>11</sup> 19 (or 29.7%) were classified as Priority “B”, and 44 (or 68.8%) were classified as Priority “C” reports. For purposes here, the term “reports” means compliance-based inquiries and compliance-based complaints. Of the 64 reports received during this period, 41 (or 64.1%) were compliance complaints received on the OCC’s anonymous toll-free compliance hotline.

**i) PRIMARY ALLEGATION CLASS**

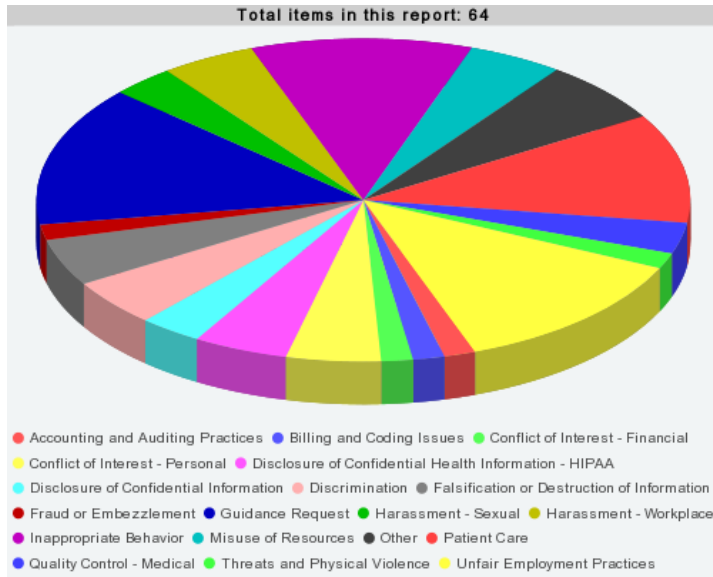


<b>CHART DATA</b>	<b>Frequency (Percentage)</b>
Diversity, Equal Opportunity and Respect in the Workplace	8.0 (12.5 %)
Employee Relations	18.0 (28.1 %)
Environmental, Health and Safety	1.0 (1.6 %)
Financial Concerns	2.0 (3.1 %)
Misuse or Misappropriation of Assets or Information	9.0 (14.1 %)
Other	13.0 (20.3 %)
Policy and Process Integrity	13.0 (20.3 %)
Totals	64.0(100%)

**ii) PRIMARY ALLEGATION TYPE**

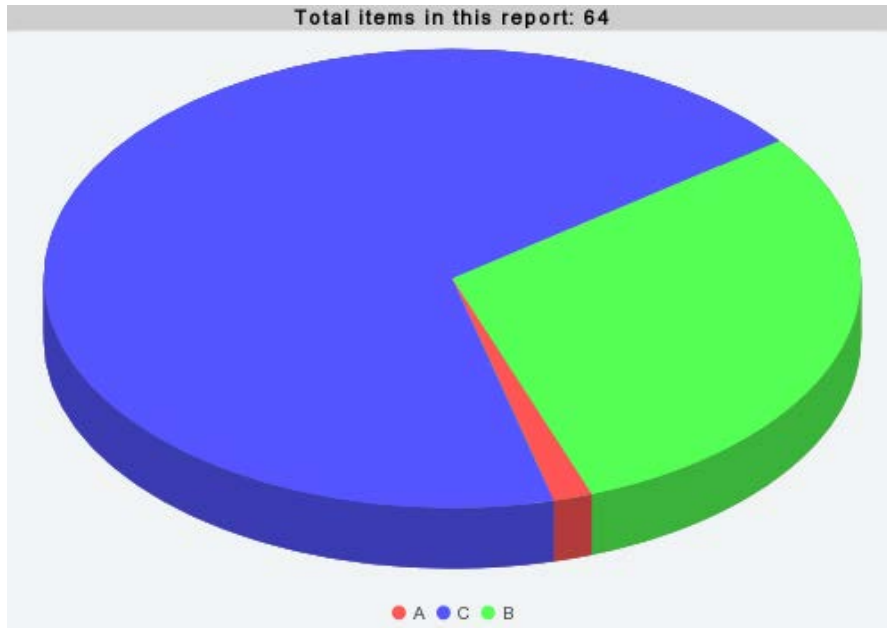
<sup>11</sup> There are three (3) different report categories: (i) Priority “A” reports - matters that require immediate review and/or action due to an allegation of immediate threat to a person, property or environment; (ii) Priority “B” reports – matters of a time-sensitive nature that may require prompt review and/or action; and (iii) Priority “C” reports – matters that do not require immediate action.





<b>- CHART DATA</b>	<b>Frequency (Percentage)</b>
Accounting and Auditing Practices	1.0 (1.6 %)
Billing and Coding Issues	1.0 (1.6 %)
Conflict of Interest - Financial	1.0 (1.6 %)
Conflict of Interest - Personal	3.0 (4.7 %)
Disclosure of Confidential Health Information - HIPAA	3.0 (4.7 %)
Disclosure of Confidential Information	2.0 (3.1 %)
Discrimination	3.0 (4.7 %)
Falsification or Destruction of Information	3.0 (4.7 %)
Fraud or Embezzlement	1.0 (1.6 %)
Guidance Request	9.0 (14.1 %)
Harassment - Sexual	2.0 (3.1 %)
Harassment - Workplace	3.0 (4.7 %)
Inappropriate Behavior	7.0 (10.9 %)
Misuse of Resources	3.0 (4.7 %)
Other	4.0 (6.2 %)
Patient Care	7.0 (10.9 %)
Quality Control - Medical	2.0 (3.1 %)
Threats and Physical Violence	1.0 (1.6 %)
Unfair Employment Practices	8.0 (12.5 %)
Totals	64.0 (100%)

iii) **PRIORITY CLASSIFICATION**



- CHART DATA	Frequency (Percentage)
A	1.0 (1.6 %)
B	19.0 (29.7 %)
C	44.0 (68.8 %)
Totals	64.0 (100%)

**V. Updating Information Governance/HIPAA Privacy and Security Operating Procedures**

Overview

1) NYC Health + Hospitals has implemented numerous measures to safeguard protected health information (“PHI”). Specifically, the System has established an information governance program to ensure the confidentiality and security of PHI. Some of the key measures implemented to ensure compliance applicable privacy and data security laws include, without limitation, the following: (i) the promulgation of policies and procedures that safeguard the privacy and security of PHI; (ii) the establishment of training programs to communicate and provide guidance to the System’s workforce on the importance of safeguarding PHI; (iii) the conducting of random corporate walk-throughs by senior compliance personnel to ensure data security quality across the System; and (iv) the procurement of outside privacy and security auditors/consultants to provide HIPAA gap analyses and audits of the privacy and security protocols currently in place System-wide.

The paragraphs that follow focus on the current HIPAA Privacy and Security Operating Procedures (“OPs”).

Legal Requirement to Promulgate and Periodically Review Policies and Procedures

2) Pursuant to 45 CFR § 164.316(a), the System is required to promulgate and periodically update, as needed, its HIPAA policies and procedures. This Federal requirement is consistent with State regulations found at 10 NYCRR § 405.3 (d)(6), which requires hospitals to review all operating procedure manuals at least on a bi-annual basis.

3) To comply with these aforementioned laws, the OCC recently assessed the following existing HIPAA Privacy and Security OPs found in the System’s OP Series 240 (which details policies and procedures concerning the use and disclosure of PHI) and System OP Series 250 (which details policies and procedures concerning the safeguarding of electronic PHI):

**List of HIPAA Privacy and Security Operating Procedures 240 & 250 Series:**

<b>OP No</b>	<b>OP Title</b>	<b>Regulation Addressed</b>
240-01	<b>Deployment Of The Corporate Privacy Notice</b>	<b>45 CFR § 164.520</b>
240-02	<b>Designated Record Sets Of Individual Patient Protected Health Information</b>	<b>45 CFR §§ 164.524, § 164.526, 164.528</b>
240-03	<b>Implementation Guidelines: Designated Record Sets Of Individual Patient Protected Health Information</b>	<b>46 CFR §§ 164.524, 164.526, 164.528</b>
240-04	<b>Patient Access to Protected Health Information</b>	<b>45 CFR § 164.524</b>
240-05	<b>Implementation Guidelines: Patient Access to Protected Health Information</b>	<b>46 CFR § 164.524</b>
240-06	<b>Patient Amendment of Protected Health Information</b>	<b>45 CFR § 164.526</b>
240-07	<b>Implementation Guidelines: Patient Amendment of Protected Health Information</b>	<b>46 CFR § 164.526</b>
240-08	<b>Privacy-Related Complaints to the Facility</b>	<b>47 CFR § 164 530(a)(1)</b>
240-09	<b>Implementation Guidelines: Addressing privacy-related complaints</b>	<b>48 CFR § 164 530(a)(1)</b>

240-10	Personal Representatives (Health Care Agents)	45 CFR §164.502(g), § 164.510(b); Office of Civil Rights HIPAA Privacy Guidance, December 3, 2002 and; N.Y. Pub. Health Law § 17, Release of Medical Records and; N.Y. Pub. Health Law § 18 and; N.Y. Pub. Health Law Article 27-F, HIV & Aids Related Information, §2782(1)(h) Confidentiality & Disclosure; N.Y. Pub Health Law, Article 29-C, Health Care Agents and Proxies, §§ 2980-2994 and; N.Y. Mental Hygiene Law, Article 9, Hospitalization of the Mentally Ill, § 9.13(a) Voluntary Admissions and; N.Y. Mental Hygiene Law, Article 81, Proceedings For Appointment Of a Guardian For Personal Needs Or Property Management
240-11	Additional Privacy Protections of Protected Health Information	45 CFR § 164.510 & § 164.522
240-12	Accounting of disclosures of Protected Health Information	45 CFR §164.528
240-13	Implementation Guidelines: Accounting of disclosures of Protected Health Information	46 CFR §164.528
240-14	Patient Authorization	45 CFR § 164.508(b)(3)(ii)
240-15	HIPAA Privacy Safeguards	45 CFR § 164.530(c)
240-16	Workforce Training	45 CFR § 164.530(b)
240-17	Uses and Disclosures of Protected Health Information for Media Interactions; Marketing/Advertising and Fundraising Activities and Community Outreach Activities	45 CFR §§ 164.502;164.514; 164.514(e)(1); 164.514(e)(2)

240-18	Uses and Disclosures of Protected Health Information of Minors	45 CFR § 164.502(g)(3); NY Mental Hygiene Law § 22.11 Treatment of minors; NY Mental Hygiene Law § 33.21 Consent for mental health treatment of minors; NY Public Health Law § 17 Release of medical records; NY Public Health Law § 18 Access to patient information; NY Public Health Law § 2305 Sexually transmissible diseases; NY Public Health Law § 2504 Enabling certain persons to consent for medical, dental, health and hospital services; NY Public Health Law § 2781 HIV related testing NY Public Health Law § 2782 Confidentiality and disclosure of HIV-related information
240-19	Uses and Disclosures of Protected Health Information of Decedents; to Coroners, Medical Examiners and Funeral Directors & for Cadaveric Organ, Eye or Tissue Donation Purposes	45 CFR §§ 164.502(f); 164.512 (f)(4),(g) and (h)
240-20	Uses and Disclosures of Genetic Information	45 CFR Parts 160 & 164; NY Civ. R. Law § 79-1 Confidentiality of records of genetic tests; NY Ins. Law § 2612 Genetic testing written informed consent
240-21	Uses and Disclosures of Mental Health Information	45 CFR Parts 160 & 164; 14 NYCRR §§ 505.7, 524.6, 524.7
240-22	Whistleblowers and Retaliatory Acts	45 CFR §§ 164.502 (j) and § 164.530(g)
240-23	Clinical Investigation and Research Policy Guidelines	45 CFR Parts 164.501, 508, 512(i), 514(e), 528, 532.
240-24	Verification Requirements for Disclosure of Protected Health Information	45 CFR § 164.51 4(h)( 1)
240-25	Uses and Disclosures Required by Law for Public Health and Oversight Activities & for Military and National Security Purposes	45 CFR §§ 164.512(a), 164.512(b), 164.512(d) and 164.512(k)

240-26	<b>Designation of Corporate and Facility Privacy Officers</b>	<b>45 CFR § 164.530(a)(l)(i) and (ii)</b>
240-27	<b>Uses and Disclosures of PHI for Law Enforcement Purposes &amp; for Judicial and Administrative Proceedings</b>	<b>45 CFR §§ 164.506, 164.508, 164.510, 164.512, 164.514, 164.520, 164.522, 164.524, 164.526, 164.528 &amp; 164.530</b>
240-28	<b>Uses and Disclosures for Treatment, Payment and Healthcare Operations</b>	<b>45 CFR § 164.506, 42 CFR § 2 .1, New York Civil Rights Law §79-l, NY Public Health Law Article 27-F, New York Mental Hygiene Law § 33.13</b>

**HIPAA Security Operating Procedures**

<b>OP No</b>	<b>OP Title</b>	<b>Regulation Addressed</b>
250-01	<b>Security Management Process</b>	<b>45 CFR §164.308(a)(1)(i)</b>
250-02	<b>Security Risk Analysis</b>	<b>45 CFR §164.308(a)(1)(ii)(A)</b>
250-03	<b>Security Risk Management</b>	<b>45 CFR §164.308(a)(1)(ii)(B)</b>
250-04	<b>Security Information System Activity Review</b>	<b>45 CFR §164.308(a)(1)(ii)(D)</b>
250-05	<b>Workstation use and Security</b>	<b>45 CFR § 164.310(b) and ©</b>
250-06	<b>Information Access Management</b>	<b>45 CFR §164.308(a)(4)</b>
250-07	<b>Assigned Security Responsibility</b>	<b>45 CFR §164.308(a)(2)</b>
250-08	<b>Workforce Security</b>	<b>45 CFR §164.308(a)(3)</b>
250-09	<b>Security Awareness and Training</b>	<b>45 CFR §§ 164.308(a)(5) and 164.530(b)</b>
250-10	<b>Incident Procedures</b>	<b>45 CFR § 164.308(a)(6)</b>
250-11	<b>Contingency Plans</b>	<b>45 CFR § 164.308(a)(7)</b>
250-12	<b>Evaluation</b>	<b>45 CFR § 164.308(a)(8)</b>
250-13	<b>Facility Access Controls</b>	<b>45 CFR § 164.310(a)</b>
250-14	<b>Audit Controls</b>	<b>45 CFR § 164.312(b)</b>
250-15	<b>Device and Media Controls</b>	<b>45 CFR § 164.310(d)</b>
250-16	<b>Access Control</b>	<b>45 CFR § 164.312(a)</b>
250-17	<b>Integrity</b>	<b>45 CFR § 164.312 (c)</b>
250-18	<b>Person and Entity Authentication</b>	<b>45 CFR § 164.312(d)</b>
250-19	<b>Transmission Security</b>	<b>45 CFR § 164.312 (e)</b>
250-20	<b>Remote Use and Access to PHI</b>	<b>45 CFR § 164.310(d)</b>

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4) Accordingly, the comprehensive review was performed by the OCC as it relates to these OPs. Such review was focused on ensuring that the following key elements were met with regard to each OP:

- All HIPAA policies appropriately addressed applicable law including, without limitation, HIPAA regulations, and facilitates compliance with such regulations;
- The scope and content of all HIPAA policies remained consistent with NYC Health + Hospitals Principles of Professional Conduct and the System's overall mission and values;
- The implementation procedures and, where applicable, internal controls, included in the HIPAA policies were sufficient to ensure legal and internal compliance; and
- The HIPAA policies have in fact been effective in ensuring HIPAA compliance.

5) Based on the review performed by the OCC, the following the following privacy topics, although already embodied in System policies and procedures, have been updated and will be, subject to legal counsel review, presented to the President for approval on or by December 12, 2017.:

- Breach response and notification OP;
- Minimum Necessary OP; and
- Business Associate Agreements OP.

6) All other HIPAA OPs listed herein have been determined by the OCC to be legally compliant, effective and current, and thus, not requiring any revisions or other amendments at this time.

**VI. Review and Updating of Compliance Policies and Procedures**

1) Pursuant to Federal and State compliance guidelines, as well as 10 NYCRR § 405.3 (d)(6), the OCC is currently reviewing its compliance policies and procedures to determine whether modification is necessary to meet applicable law; compliance best practice standards; and the System's transformation and evolving vision.

2) OP 50-1 was determined to require updating, and was accordingly revised. OP 50-1 was presented to the Audit Committee of the NYC Health + Hospitals Board of Directors as an information item on today's Audit Committee agenda.

3) The OCC has finalized the following Operating Procedures, which are undergoing final legal review.

- OP 50-2 (The Prohibition of Activities that Violate the Civil Monetary Penalties Law and/or Result in the Imposition of Civil Monetary Penalties);
- OP 50-3 (Compliance with the Federal and State False Claims Acts, and Federal and State Laws Related to the Commission of Health Care Fraud);
- OP 50-5 (Mandatory Reporting and Refunding of Overpayments); and
- OP 50-7 (Emergency Medical Treatment and Active Labor Act (“EMTALA”))

These Operating Procedures will be presented to the President for approval in December. The Compliance Plan and Guide to Compliance will be updated accordingly to reflect the finalization of these Operating Procedures.

## **VII. Compliance with the Deficit Reduction Act of 2005 Requirements**

### Deficit Reduction Act of 2005 Compliance Requirements

1) Pursuant to the Deficit Reduction Act (hereinafter also referred to as “DRA”) of 2005, the System is required, as a condition of its participation in Medicaid, to establish written policies and procedures that inform its “Workforce Members” (e.g., employees, affiliates, personnel, medical staff members, governing body members, trainees, volunteers, appointees, agents and individuals whose conduct is under the direct control of the System, whether or not they are paid directly by the System) and “Business Partners” (e.g., all non-workforce member contractors, subcontractors, vendors or other third parties who, acting on behalf of the System, deliver, furnish, prescribe, direct, order or otherwise provide Federal healthcare program items and services) about the following:

- The System’s internal policies covering the prevention and detection of Federal healthcare program fraud, waste, and abuse;
- The Federal False Claims Act and any similar law under the State of New York (the “State”) that governs false claims and statements;
- The Federal administrative remedies for false claims and statements;
- Any State law pertaining to civil or criminal penalties for false claims and statements; and



- Whistleblower protections under Federal and State laws.

Deficit Reduction Act Memorandum 2017

2) During the month of September 2017, the Office of Corporate Compliance met its DRA obligations as described above by distributing a DRA Memorandum as follows: (i) via email to all Workforce Members; (ii) hand delivery to Workforce Members without ready access to computers; and (iii) via email to all Business Partners. The DRA Memorandum contained the following information:

DRA Memorandum Summaries of the System’s Policies and Procedures Covering the Prevention and Detection of Fraud, Waste and Abuse

3) The following are the System’s policies and procedures designed to prevent and detect fraud, waste and abuse summarized in the DRA Memorandum:

- the System’s Corporate Compliance Plan (the “Plan”);
- the System’s Operating Procedure 50-1 - Corporate Compliance Program (“OP 50-1”);
- the System’s Principles of Professional Conduct (“POPC”);
- Guide to Compliance at NYC Health + Hospitals (“Guide to Compliance”)
- Memorandum from the System’s Chief Corporate Compliance Officer Regarding Medicare Parts C and D Training

Federal and State Laws relating to False Claims and Statements Summarized in the DRA Memorandum

4) The following are Federal and State laws relating to false claims and statements which are summarized in the DRA Memorandum:

*FEDERAL LAWS*

- Federal False Claims Obligation (42 USC §1396a (a)(68))
- Federal False Claims Act (31 USC §§ 3729-3733)
- Administrative Remedies for False Claims (31 USC Chapter 38,

Sections 3801-3812)

*NEW YORK STATE LAWS*

CIVIL AND ADMINISTRATIVE LAWS

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

CRIMINAL LAWS

- Social Services Law, Section 145 - Penalties
- Social Services Law, Section 366-b - Penalties for Fraudulent Practices.
- Penal Law Article 155 - Larceny
- Penal Law Article 175 - False Written Statements
- Penal Law Article 176 - Insurance Fraud
- Penal Law Article 177 - Health Care Fraud

Federal and State Laws relating to Whistleblower Protection

5) The following are Federal and State Whistleblower Protection laws as detailed in the DRA Memorandum:

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

Annual DRA Compliance Certification Filed with OMIG

6) Because the System received over \$ 5million in Medicaid funds, it is required to file a certification of DRA compliance with the Office of Medicaid Inspector General (“OMIG”). The DRA Compliance Certification must be filed with OMIG in December 2017 and covers the Federal Fiscal year – October 1, 2016 to September 30, 2017. The Chief Compliance Officer for the System, shall affirm the System’s compliance with the mandated DRA obligations with certification by the System’s President and Chief Executive Officer.

## **VIII. Status Update – DSRIP Compliance Activities**

### Background

1) As previously reported to the Audit Committee in September 2017, as a Performing Provider System (“PPS”) lead in the New York State Department of Health Delivery System Reform Incentive Payment (“DSRIP”) Program, NYC Health + Hospitals/OneCity Health (“OneCity Health”) is responsible for taking “reasonable steps to ensure that [M]edicaid funds distributed as part of the DSRIP program are not connected with fraud, waste, and abuse. It is reasonable for a PPS Lead to consider its network performing providers’ program integrity systems when dedicating resources and developing the PPS Lead’s systems.”<sup>12</sup> To satisfy its compliance obligations as the PPS Lead and to fulfill the requirements of the Office of Medicaid Inspector General (“OMIG”) DSRIP compliance guidance, OneCity Health developed a compliance Attestation form, which was designed to assess the compliance program integrity of its Partners.

### Overview of Compliance Attestations

2) In February, 2017, all OneCity Health Partners were provided with a Memorandum from the OCC, which included as an attachment a *Compliance Attestation of OneCity Health Partners* (“Attestation”). The Attestation was intended to provide OneCity Health with a critical snapshot of the compliance foundation of its Partners.

### *Overview and Analysis of the Key Components of the OneCity Health Partner Compliance Attestation*

- 3) The Attestation addressed, among other things, the following key topics;
- The status of completion of mandatory DSRIP compliance training by their medical practice or organization;
  - An acknowledgment by Partners that their workforce members adopted the *NYC Health + Hospitals Principles of Professional Conduct* (“POPC”) or their own organization’s code of conduct that includes the POPC’s core objectives or substantially similar compliance goals; and

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<sup>12</sup> Office of the Medicaid Inspector General Delivery System Reform Incentive Payment (“DSRIP”) Program DSRIP Compliance Guidance 2015-01 –revised – Special Considerations for Performing Provider System (“PPS”) Leads’ Compliance Program available at: [https://www.omig.ny.gov/images/stories/compliance\\_alerts/20150901\\_DSRIP\\_CompGuidance\\_2015-01\\_Rev.pdf](https://www.omig.ny.gov/images/stories/compliance_alerts/20150901_DSRIP_CompGuidance_2015-01_Rev.pdf)

*Total Number of Attestations Completed and Returned to OneCity Health*

4) Of the 193 OneCity Health Partners, who executed a Schedule B for period April 2017 to December 2017, all 193 Partners had completed and submitted the Attestation to OneCity Health. The Schedule B is a contract amendment to the DSRIP Master Services Agreement signed by each OneCity Health Partner that outlines performance requirements to earn DSRIP funding (“funds flow”).

*DSRIP Compliance Training Completed by OneCity Health Partners*

5) In December 2016, the OCC provided all OneCity Health Partners with a DSRIP Compliance Training PowerPoint Presentation. The Partners were informed that they could use the PowerPoint Presentation to complete the DSRIP compliance training requirement in any one or combination of the following 3 ways:

- Use the PowerPoint in In-Person/live compliance and education training;
- Incorporate PowerPoint content into existing compliance training computerized modules; or
- Distribute the PowerPoint to workforce members involved or associated with or otherwise affected by the DSRIP program.<sup>13</sup>

All 193 of the OneCity Health Partners attested that they conducted DSRIP Compliance Training.

*Adoption of the POPC or Similar Code of Conduct*

6) The Partners were asked if they adopted the POPC or their own organization’s code of conduct that includes the POPC’s core objectives or substantially similar compliance goals. Only one Partner responded that they did not adopt the POPC or a similar code of conduct. The OCC has requested a copy of its code of conduct to ensure adequacy.

Updated DSRIP Compliance Plan

7) New York Social Services Law Section 363-d and Title 18 of the New York Codes Rules and Regulations at Part 521 outline the required elements of an effective compliance program. In addition to these required elements, on September 1, 2015 the New York State Department of Health and Office of Medicaid Inspector General (“OMIG”) issued guidance entitled *Special Considerations for Performing Provider System (PPS) Lead’s Compliance Programs* (the “Guidance”). Based on the foregoing, in 2015 NYC Health + Hospitals OCC developed a Compliance Plan for OneCity Health/DSRIP.

8) One required element of an effective compliance program is an ongoing process to identify and assess risks. The OMIG has identified the misuse of DSRIP funds as a potential risk. Additionally, in pertinent part the Guidance states as follows: “It is expected that as the DSRIP program develops PPS Leads’ compliance programs will develop to include additional considerations.” Accordingly, the OCC reviewed and modified the OneCity Health/DSRIP Compliance Plan to meet current requirements.

9) The key elements of the revised One City Health DSRIP Compliance Plan are as follows:

- Background of NYC Health + Hospitals/OneCity Health DSRIP Program
- Roles of DOH, State Office of Medicaid Inspector General (“OMIG”) and Independent Assessor
- DSRIP Compliance Program Elements
- DSRIP Privacy Related Matters
- New York State Public Authorities Accountability Act

Audit of OneCity Health DSRIP Program by Outside Auditor

10) Responses to a Request For Proposal (“RFP”) from Outside Auditing Firms to Audit the OneCity Health DSRIP Program are due on December 15, 2017. The Chief Corporate Compliance Officer will be part of the five member committee to review the RFPs.

**IX. Status Update - HHC ACO, Inc. Compliance Activities**

Background of HHC ACO, Inc.

1) Accountable Care Organizations are groups of health care providers who come together under an arrangement authorized by the Affordable Care Act to coordinate care, reduce costs and improve quality for its patients. This arrangement links the payment for caring for patients covered by Medicare fee-for-service to their health outcomes. During the course of the year CMS offers reimbursement for care provided to these patients. At the end of the year, the costs are reconciled with a benchmark. If the total cost of care provided to Medicare patients is lower than the benchmark, and the quality of care provided meets or exceeds certain outcome standards, the ACO earns a bonus payment based on the savings.

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2) During 2016, HHC ACO achieved a quality score of 90% and it reduced costs to Medicare by more than \$31 million and generated shared savings incentive payments of nearly \$14 million over the four years of the program.<sup>14</sup>

HHC ACO, Inc. Application for New York State ACO Certificate of Authority

3) On October 5, 2017, HHC ACO, Inc. (“HHC ACO”) submitted an application to the New York State Department of Health (“DOH”) seeking approval for an “all payer” ACO that includes Medicaid, commercial insurance and Medicare Advantage patients. Currently, HHC ACO only provides care to Medicare fee-for-service patients. If the application is approved by DOH, this expanded ACO will cover a much larger patient population. As part of the application, the Office of Corporate Compliance provided as exhibits the following three draft documents:

- Draft revised HHC ACO Compliance Plan;
- Draft HHC ACO Standards of Conduct; and
- Draft HHC ACO Compliance Training and Education PowerPoint Presentation

4) The HHC Standards of Conduct and Compliance Plan will be submitted for approval at the December 2017 HHC ACO Board of Directors meeting.

*Revised Draft Compliance Plan*

5) The Medicare Shared Savings Program (“MSSP”) regulations can be found at 42 CFR Part 425. These regulations require that all ACO’s have a Compliance Plan.<sup>15</sup> The ACO compliance plan must include at least the following 5 elements<sup>16</sup>:

- A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body.
- Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance.
- A method for employees or contractors of the ACO, ACO participants, ACO providers /suppliers, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the compliance officer.

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<sup>14</sup> NYC Health + Hospitals *Insider*, dated November 13, 2017

<sup>15</sup> 42 CFR 425.300(a)

<sup>16</sup> 42 CFR 425.300 (a) (1-5)

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- Compliance training for the ACO, the ACO participants, and the ACO providers/suppliers.
- A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

6) The MSSP regulations provide that “[a]n ACO's compliance plan must be in compliance with and be updated periodically to reflect changes in law and regulations.”<sup>17</sup>

7) The OCC has prepared a revised draft HHC ACO Compliance Plan. The revised draft HHC ACO Compliance Plan addresses, without limitation, the following topics:

- Overview of accountable care organizations
- Medicare Shared Savings Program (“MSSP”) Requirements
- Background of HHC ACO
- HHC ACO Governance
- HHC ACO Participation Agreements
- ACO Regulatory Requirements
- Conflicts of Interest
- Required elements of an ACO compliance program
- Reporting HHC ACO compliance issues
- Overview of New York State Accountable Care Organization
- New York State Public Authorities Law

*HHC ACO, Inc. Draft Standards of Conduct*

8) The NYC Health + Hospitals Principles of Professional Conduct (“POPC”) was adopted by the NYC Health + Hospitals Board of Directors in April 2016. When the POPC was being developed it was determined by the Office of Corporate Compliance and legal counsel that because of the unique compliance and regulatory requirements for ACOs, a HHC ACO Standards of

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<sup>17</sup> 42 CFR 425.300 (b)(2)

Conduct (“SOC”) modeled on the POPC should be developed. Accordingly, a draft HHC ACO Standards of Conduct has been developed by the OCC for use by HHC ACO staff, participants and providers/suppliers.

9) The SOC is a guide that sets forth HHC ACO’s compliance expectations and commitment to comply with all applicable Federal and State laws. It describes the ACO’s standards of professional conduct and efforts to prevent fraud, waste, and abuse. Some of the topics included in the SOC are as follows:

- Who does the SOC apply to?
- SOC Core Objectives;
- Responsibilities of HHC ACO personnel under the SOC;
- Examples of Unprofessional Conduct;
- What happens if you engage in unprofessional conduct or otherwise violate the SOC?
- How to report issues or violations; and
- Prohibition of Retaliation/Whistleblower protection.

*HHC ACO, Inc. Training Materials*

10) During calendar years (“CY”) 2015 and 2016, the OCC provided compliance training to over 27,000 people. Most of the training was computer-based. There were four computer-based training modules for each of Physicians, Healthcare Professionals, General Workforce and NYC Health + Hospitals Board of Directors. Each of these modules had a training section on the HHC ACO and ACO compliance. New computer-based compliance training modules, including ACO compliance training, is scheduled to launch this month.

11) The OCC has prepared a draft HHC ACO Compliance Training and Education PowerPoint presentation to train HCO ACO staff, participants and providers regarding relevant compliance topics. The PowerPoint has the following 4 sections:

- About HHC ACO
  - What is an MSSP ACO?
  - HHC ACO Leadership and Participants;
  - HHC ACO Governance;



- HHC ACO Quality Performance Results, Mission and Goals;
- HHC ACO Participation Agreements; and
- HHC ACO Conflicts of Interest Policy
  
- Medicare Shared Savings Program Overview
  - Prohibition Against Patient Inducement;
  - Prohibition Against Patient Avoidance;
  - Accuracy of Data; and
  - Achievement of Quality Performance Standards
  
- Laws and Regulations that Govern ACO Compliance
  - Required elements of a MSSP ACO Compliance Plan;
  - Laws and Regulations that Govern MSSP ACO Compliance; and
  - Summaries of Federal False Claims Act; Stark Law; Anti-kickback Statute; Civil Monetary Penalties Law; Criminal Health Care Fraud Statute; Exclusion Authorities; and New York State False Claims Act.
  
- Reporting ACO Compliance Issues
  - Instructions on How to Report a Suspected Violation of law or policy