NYC HEALTH+ HOSPITALS

Mitchell Katz, M.D.
President and CEO
NYC Health + Hospitals
50 Water Street, 17th Floor
New York, NY 10004

Operating Procedure 50-1[1]

CORPORATE COMPLIANCE AND ETHICS PROGRAM

TO: All NYC Health + Hospitals Workforce Members
All NYC Health + Hospitals Business Partners
Distribution "E"[2]

FROM: Mitchell Katz, M.D.
President and Chief Executive Officer

DATE: April 25, 2023

TABLE OF CONTENTS

[1] This Operating Procedure ("OP" or "Policy") supersedes and replaces OP 50-1 (Corporate Compliance and Ethics Program) dated January 5, 2018, and any subsequent changes thereto, in their entirety.
[2] *See* Operating Procedure 10-11 for the titles of the individuals covered under Distribution "E".

I. POLICY:

It is the policy of NYC Health + Hospitals (the "System")[3] to establish, monitor, and maintain an effective Compliance Program centered on:

A. Ensuring that the System's operations and business practices are conducted in a manner that:

(i) Complies with all Federal and New York State ("State") laws;[4] and

(ii) Represents the System's commitment to maintain its status as a reliable, honest, and trustworthy healthcare provider;

B. Identifying and eliminating fraud, waste, and abuse;

C. Assessing, prioritizing and mitigating System-wide risks;

D. Promoting and fostering a climate of ethical conduct and good governance;

E. Establishing compliance policies and procedures;

F. Investigating allegations of misconduct; and

G. Providing training and communications.

II. PURPOSE

The purpose of the Compliance Program is to:

A. Promote an organizational environment that focuses on the prevention, detection, and correction of any departure from the System's legal, regulatory, professional, fiduciary, and ethical obligations, especially as they relate to the following:

(i) Fraud, waste, and abuse;

(ii) Federal and State healthcare program conditions of participation, as well as private payor requirements;

---

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

[4] 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 criminal, civil, and administrative laws, codes, rules, and regulations.

(iii) Information governance;

(iv) Corporate governance;[5]

(v) The establishment and monitoring of effective internal controls;[6] and

(vi) The System's own internal policies, business practices, and ethical standards of conduct.

B. Under the direction of the Chief Corporate Compliance Officer ("CCO") within the Office of Corporate Compliance ("OCC"), serve as an established resource within the System to:

(i) Proactively identify and address System-wide compliance issues and concerns;

(ii) Exercise due diligence to deter fraud, waste and abuse, as well as unprofessional, unethical, and criminal conduct;

(iii) Partner with System facilities and departments to accomplish System goals and increase transparency of compliance obligations; and

(iv) Promote a culture of integrity and ethics.

III. APPLICABILITY

NYC Health + Hospitals is a large, multifaceted health care system, with many different components and subsidiaries, including a health plan and an Accountable Care Organization, among others. This OP applies to all individuals who are employed by or affiliated with the System, including Workforce Members and Business Partners, as defined herein (collectively referred to as "Covered Persons"). The System recognizes that some of its subsidiaries have their own compliance programs, and this OP supplements those programs. In addition, the CCO will coordinate, as appropriate, with the Chief Compliance Officer of MetroPlus, which has its own compliance program and policies.

IV. DEFINITIONS

A. Compliance: Compliance is the ongoing process of meeting or exceeding an

[5] *See* 18 NYCRR § 521-1.3(d)(6).
[6] *See* 63 Fed. Reg. 8987, 8987 (Feb. 23, 1998) (stating that hospitals "develop effective internal controls that promote adherence to applicable Federal and State law, and the program requirements of Federal, State and private health plans.").

organization's applicable legal, ethical, and professional standards. A culture of compliance fosters the prevention, identification and remediation of conduct that fails to comply with applicable law and/or an organization's own ethical and business policies. The System is committed to a culture of compliance and it expects all Covered Persons to conduct themselves in manner that is consistent with this commitment.

B. Ethics: Do the Right Thing. Ethics is about the moral standards that guide behaviors. The System is committed to ethical conduct and expects all Covered Persons to conduct themselves in an ethical and legal manner.

C. Integrity: Integrity is the behavior that supports Ethics. Integrity is about Covered Persons' conduct and behavior.

Examples of Ethics and Integrity include the following:

(i) Acting fairly and honestly;

(ii) Following applicable industry practices that are lawful, fair, and non-deceptive in nature;

(iii) Adherence by professionals to applicable ethical standards of conduct dictated by their respective professional organizations;

(iv) Reporting compliance violations ("Compliance Reporting"); and

(v) Adhering to ethical standards in all you do.

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

(i) Employees;

(ii) Affiliate employees;[7]

(iii) Members of the System's medical staff;

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

(iv) Members of the NYC Health + Hospitals Board of Directors and their designee agents (the "Board of Directors");

(v) Directors of NYC Health + Hospitals wholly owned subsidiaries;

(vi) Members of the Gotham Health FQHC, Inc. ("Gotham Health"), Board of Directors;

(vii) Interns;

(viii) Trainees;

(ix) Students;

(x) Volunteers; and

(xi) Any individual whose conduct, in the performance of their work functions and duties on behalf of the System, is under the direct control of the System, whether or not they are paid by the System.

E. Business Partner: For purposes of this OP, the term Business Partner means any non-Workforce Member, contractor, subcontractor, vendor or other third-party (collectively "Third Parties") that is required by law or contract to comply with this OP, and that, in acting on behalf of or otherwise being associated with NYC Health + Hospitals, engages in activities, functions, and duties that:

(i) Contribute to the System's entitlement to receive payment from Federal healthcare programs or private payors,[8] including, for example, those Third Parties that deliver, furnish, prescribe, direct, order or otherwise provide healthcare items and/or services; or

(ii) May place the System at risk of significant noncompliance with Federal health care program or private payor requirements, or fraud, waste and abuse prohibitions, including, for example, those Third Parties that:

(a) Provide billing or coding functions;[9] or

[8] *See* New York State Office of the Medicaid Inspector General ("OMIG") Compliance Program Review Guidance – *New York State Social Services Law Section 363-d and Title 18 New York Codes, Rules and Regulations Part 521 Compliance Program Review Guidance* (Oct. 26, 2016) (hereinafter "OMIG Compliance Program Review Guidance") at p. 3.

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

(b) Monitor the health care provided by the System.[10]

F. Fraud, Waste, and Abuse: The terms fraud, waste, and abuse may have various technical definitions under numerous laws and regulations. Any questions or concerns related to the meaning of these terms should be referred to the OCC for clarification. These terms are generally defined as follows:

(i) Fraud is an intentional deception or misrepresentation made with the knowledge that the deception/misrepresentation could result in some unauthorized benefit to the individual or entity making such deception/misrepresentation or someone else.[11]

(ii) Waste is the overuse of services or other practices that, directly or indirectly, results in unnecessary costs to a Federal healthcare program (*e.g.*, Medicare, Medicaid, and Tricare). Generally, waste is not the result of criminally negligent actions, but rather an end product of the misuse of resources.[12]

(iii) Abuse is any action that may directly or indirectly result in an unnecessary cost to a Federal healthcare program and involves payments for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.[13]

Note: Operating Procedure 50-2 "Policy on Fraud, Waste and Abuse, and False Claims" further defines the terms *Fraud*, *Waste,* and *Abuse* and provides examples for each of these terms.

V. SCOPE

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

A. All acute care facilities;

B. All diagnostic and treatment centers ("D&TCs") (including those designated as Federally Qualified Health Centers ("FQHCs") and associated neighborhood and school-based health centers);

C. All long-term acute care facilities and skilled nursing facilities;

---

[10] *See id.*
[11] 18 NYCRR § 515.1(b)(7); 42 CFR § 455.2.
[12] *See* CMS Combatting Medicare Parts C & D Fraud, Waste and Abuse Web-Based Training Course, rev. 1/17 ("CMS Training"), Lesson 1 Page 3 ("L1P3"), pg. 14, available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf.
[13] *Id.*

D. NYC Health + Hospitals/Community Care ("Community Care");

E. Correctional Health Services;

F. All Central Office locations; and

G. All subsidiary corporations.

VI. COMPLIANCE PROGRAM REQUIREMENTS

The System maintains an effective compliance program, as defined by State law and Federal guidance by:[14]

A. Promulgating written policies and procedures that outline a code of conduct, guidance to Covered Persons on how to deal with and report potential compliance concerns ("Compliance Concerns"), how the Compliance Program investigates and resolves Compliance Concerns, and other matters covered by 18 NYCRR § 521-1.4;

B. Appointing a CCO responsible for the Compliance Program's day-to-day operation;

C. Establishing an enterprise-wide Compliance Committee that is responsible for coordinating with the CCO to ensure that the System conducts its business in an ethical and responsible manner, consistent with its Compliance Program.

D. Providing training and education for all Workforce Members and Business Partners, as appropriate;

E. Establishing communication lines accessible to all Covered Persons and the System's Medicaid recipients for reporting Compliance Concerns, including the ability to report anonymously;

F. Establishing disciplinary policies to encourage good faith participation in the Compliance Program, including policies that articulate expectations for Compliance Reporting, resolving compliance issues, and outlining disciplinary actions for failing to report suspected problems, participating in non-compliant behavior or encouraging, directing, facilitating or permitting (either actively or passively) non-compliant behavior;

G. Establishing and implementing an effective system for routinely monitoring and identifying compliance risk areas by conducting periodic risk assessments, and

[14] *See* 18 NYCRR § 521-1.4; *see generally*, 63 Fed. Reg. at 8987.

implementing an auditing and Compliance Program review program that meets the requirements of 18 NYCRR § 521-1.4(g);

H. Addressing Compliance Concerns brought to the attention of the OCC; and

I. Establishing a non-intimidation and non-retaliation whistleblower policy.

VII. RISK AREAS

A. The Compliance Program applies to the following risk areas:[15]

(i) Billing;
(ii) Payments;
(iii) Ordered services;
(iv) Medical necessity;
(v) Quality of care
(vi) Governance, including issues such as ensuring compliance with conflicts of interest;
(vii) Mandatory reporting;
(viii) Credentialing;
(ix) Contractor, subcontractor, agent or independent contractor oversight; and
(x) Other risk areas that should reasonably be identified through the System's operational experience, and which will be addressed as appropriate by the Compliance Program or others.

B. The Compliance Program audits and monitors the above risk areas in the following manners:

(i) Engaging external agencies and internal resources for auditing billing, payments, ordered services and medical necessity;
(ii) Working with the Quality Assurance Program to ensure quality of care;
(iii) Providing training and education on Chapter 68 of the New York City Charter, referred to as the Conflicts of Interest Law, and internal policies on conflicts of interest;
(iv) Ensuring that the CCO reports directly to the President and Chief Executive Officer and to the Audit Committee of the System's Board of Directors;
(v) Coordinating with the System's Credentialing Department; and
(vi) Coordinating with Supply Chain/Procurement for oversight of contractors,

[15] 18 NYCRR § 521-1.3(d).

subcontractors, agents, and independent contractors.

VIII. OFFICE OF CORPORATE COMPLIANCE ("OCC")

A. Responsibilities of the OCC

(i) The OCC is led by the CCO, and includes, at the discretion of the CCO, compliance personnel such as a First Deputy Corporate Compliance Officer, Deputy Corporate Compliance Officer(s), and Executive and Senior Compliance and Privacy Officers ("CPOs").

(ii) The OCC, under the direction of the CCO, is responsible for implementing the Compliance Program.

(iii) The OCC, under the direction of the CCO, is responsible for revising and implementing System procedures related to the Compliance Program.

(iv) Reporting of Compliance Violations - Cooperation by Covered Persons with Compliance Reviews

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

1) The System strictly prohibits Retaliation against any Covered Person who reports, in good faith, the actual, potential or suspected commission of a Prohibited Act, as defined in § XVI(C); and

2) The confidentiality of the Covered Person's good faith report will be maintained to the extent allowed by law and in accordance with the System's internal policies and procedures.

(v) Investigations[16]

(a) Under the direction of the CCO, the OCC compliance personnel shall perform (or direct the performance of), with appropriate due diligence, a prompt, fair, impartial, and thorough investigation in

[16] *See* the OCC Investigations Manual for detailed information on the OCC's conduct of investigations.

response to all reports that are brought to the OCC in good faith, and for which the OCC is provided sufficient information to conduct an investigation, unless referral to another department or entity is appropriate.

(b) Conduct of Investigation

1) Unless otherwise mandated by applicable Federal or State law, all investigations conducted shall be conducted with due diligence to determine whether there is credible evidence that a probable material commission of a Prohibited Act has occurred.[17]

2) Investigations may include gathering evidence, conducting interviews, reviewing relevant documents, and engaging outside counsel or auditors as appropriate.

(c) Confidentiality and Anonymity

1) Reporters may report compliance matters in good faith through the OCC toll free confidential Helpline, at 1-866-HELP-HHC (1-866-435-7442), through a CPO, or to the OCC directly. All reports will be handled by OCC personnel confidentially.

2) Reporters may elect not to provide their name or other identifying information when making a Report. In carrying out their investigatory functions, duties, and responsibilities, all CPOs, and other OCC personnel, shall make every reasonable effort, to the best of their ability, and to the fullest extent allowable by law and System policies and procedures, to preserve the anonymity of Reporters when requested and when reports are made in good faith.[18]

(vi) Compliance with the Deficit Reduction Act ("DRA") of 2005

(a) In accordance with the DRA, the OCC establishes and maintains a policy on compliance with the Federal False Claims Act, which is enforced by administrative remedies for false claims and statements, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws; and includes as part of such written policy detailed provisions

[17] *See* 63 Fed. Reg. 8987, 8997 § II(G)(1).
[18] HCCA Code of Ethics for Health Care Compliance Professionals, Principle II, R2.5 (commentary).

regarding the System's policies and procedures for detecting and preventing fraud, waste, and abuse.

(b) The System distributes such policy annually to all workforce members, contractors, and other entities affiliated with the System.

B. Operation of the OCC

(i) The CCO meets regularly with the CPOs to inform the CPOs of System-wide developments, discuss current and emerging compliance and privacy issues, track progress on the remediation of Work Plan items, and address complex compliance matters;

(ii) The CCO also meets individually with the CPOs regularly to address their current workload and address any issues therewith;

(iii) Maintains the System's compliance case management system;

(iv) Conducts monthly exclusions screenings;

(v) Develops annual compliance and Health Insurance Portability and Accountability Act of 1996 ("HIPAA") training and targeted risk-based trainings;

(vi) Develops and implements a communication plan to inform Workforce Members about the operations of the OCC and the Compliance Program;

(vii) Maintains a proactive patient privacy monitoring system to identify potential inappropriate access to protected health information ("PHI"); and

(viii) Maintains the System's library of System-wide policies and procedures.

C. Chief Corporate Compliance Officer ("CCO")

(i) The System's President and Chief Executive Officer (the "President") shall appoint the System's CCO, who must be an employee of NYC Health + Hospitals. The CCO shall be responsible for the day-to-day operation of the Compliance Program,[19] operating the OCC and directing all compliance-related activities.

[19] 18 NYCRR § 521-1.4(b).

(ii) The CCO reports directly to the President and Chief Executive Officer, and to the Audit Committee of the Board of Directors (the "Audit Committee"), and the Audit Committee will have direct access to the CCO.[20]

(iii) The CCO shall select and train personnel to conduct and enforce the Compliance Program activities and requirements.

(iv) The CCO will report on significant compliance activity in scheduled meetings of the Audit Committee.[21]

(v) The CCO, at their discretion, may report directly to the Chairperson of the Audit Committee on selected matters.

(vi) The CCO will meet periodically with the Governing Body and leadership of System subsidiaries, as appropriate.

(vii) Where appropriate, the CCO will make external reports to the appropriate Federal, State, and local regulatory bodies and/or law enforcement agencies.

(viii) All OCC personnel will report directly to the CCO (or their designee).

(ix) The System's Corporate Records Management Officer ("CRMO"), who is the individual charged with developing, coordinating, and overseeing the System's Corporate Records Management Program,[22] reports directly to the CCO.

(x) The CCO provides oversight of the Compliance Program, including:

(a) Developing, operating, overseeing, and monitoring the implementation of the Compliance Program;[23]

(b) Serving as the focal point for the System's compliance activities;[24]

(c) Assisting the Governing Body, President, members of the Enterprise Compliance Committee ("ECC"), and other System compliance committees in establishing methods to improve the System's

[20] Id. at § 521-1.4(b)(iv).
[21] *See id.*
[22] *See* 8 NYCRR § 185.1[a]; *see also* subdivision "*c*" of § VIII of NYC Health + Hospitals OP 120-19 (*Corporate Record Management Program*). Note that, the System's Record Management program shall be operated in accordance with OP 120-19.
[23] *See*, 63 Fed. Reg. 8987, 8993.
[24] *See id.*

efficiency and quality of services, and reduce the System's vulnerability to fraud, waste, and abuse; and

(d) Reporting on a regular basis to the System's Audit Committee, President, and the ECC on the progress of implementation, and assisting these components in establishing methods to improve the System's efficiency and quality of services, and to reduce the System's vulnerability to fraud, abuse and waste.[25]

(xi) The CCO periodically reviews and revises as necessary the Compliance Program, as appropriate, in response to:[26]

(a) The System's needs, mission, and goals;

(b) Applicable Federal and State laws and guidance, and payor policies and procedures; and

(c) Industry best practices or guidance.

(xii) The CCO ensures that independent contractors and agents who furnish medical services to the System are aware of the requirements of the System's Compliance Program with respect to coding, billing, and marketing, among other things.[27]

(xiii) With the support of the OCC staff, the CCO independently investigates and acts on matters related to compliance, including responding to reports of problems or suspected violations and any resulting corrective action. [28]

(xiv) The CCO develops policies and programs that encourage Workforce Members to report suspected fraud and other improprieties without fear of retaliation.[29]

(xv) With the support of the OCC staff, the CCO develops the Compliance and HIPAA Training Programs.

(xvi) The CCO issues advisories to the System facilities and/or departments to

[25] *See id.*
[26] *See id.*
[27] *See id.* at 8894.
[28] *See id.*
[29] *See id.*

raise awareness of known or potential compliance vulnerabilities and risks, and to alert them to changes in relevant:

(a) Federal and State laws and guidance; and
(b) Federal healthcare program and private payor requirements.

(xiii) In conjunction with the OCC staff, the CCO prepares periodic System-wide Risk Assessments and presents them to the ECC for review and approval.

(ix) Upon approval of the Risk Assessments by the ECC, the CCO prepares periodic System-wide Corporate Compliance Work Plans ("Work Plans") to be approved by the ECC. The CCO then presents the Work Plans to the Audit Committee for approval, and to the President for their signature.

(xx) Upon the approval of the Audit Committee and signature by the President, the OCC, as directed by the CCO, implements the Work Plans.

(xxi) The CCO assigns Work Plan items to responsible individuals or departments for review and the development of corrective action plans as necessary.

(xxii) The CCO initiates and conducts periodic targeted System-wide compliance review(s) or audit(s) as the CCO deems necessary.

(xxiii) The CCO oversees and maintains a confidential process, including a toll-free confidential compliance helpline, to receive reports of compliance issues, and ensuring the use of procedures to protect the anonymity of reporters and to protect whistleblowers from retaliation.[30]

(xxiv) The CCO reports compliance issues and concerns to the Board of Directors, as necessary.

(xxv) In conjunction with the OCC staff, the CCO develops compliance policies and procedures that:

(a) Provide Workforce Members and Covered Persons where appropriate, with guidance on compliance issues and concerns;[31]
(b) Educate Workforce Members, and other Covered Persons where appropriate, on ethical behaviors and program mandates; and

---

[30] *See id.* at 8995.

[31] *See* OIG HHS Association of Healthcare Internal Auditors, American Health Lawyers Association and Health Care Compliance Association, *Practical Guidance for Health Care Governing Board on Compliance Oversight, Roles and Relationships* [The compliance function], p. 6, available at https://oig.hhs.gov/documents/root/162/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf.

(c) Facilitate compliance with the Compliance Program by Workforce Members and other Covered Persons where appropriate.

(xxvii) With the support of OCC staff, the CCO develops metrics and other measurements to assess the execution and effectiveness of the Compliance Program, the implementation of remedial measures and mitigation efforts, and the development of reports and dashboards to assist the Audit Committee in its evaluation of the Compliance Program;[32]

(xxviii) The CCO establishes and implements the System's Non-Intimidation and Non-Retaliation Whistleblower Policy.

(xxix) The CCO may refer to appropriate employees, departments or compliance workgroups or committees (such as, for example, Inspector General, Office of Legal Affairs, Human Resources/Talent Acquisition, Labor Relations or a member of the ECC or a subcommittee thereof) the responsibility to conduct reviews of issues of concern including, for example, Work Plan items or non-compliance related reports made to the OCC, if the CCO deems such reviews are necessary to fulfill the mission of the Compliance Program.

(xxx) The CCO may, as needed, retain outside consultants such as investigators, attorneys, auditors, training specialists or others with specific expertise to assist in selected reviews or the development of the Compliance Program in accordance with System policies and procedures.[33]

(xxxi) The CCO will review and revise the Compliance Program and the System's compliance policies and procedures and the Principles of Professional Conduct ("POPC"), to incorporate changes in the System's organizational experience and changes to applicable laws, regulations, policies, and standards.

(xxxii) The CCO will coordinate the implementation of a fraud, waste, and abuse prevention program with Medicaid Managed Care Organizations' Special Investigation Units.

(xxxiii) Supervising the Activities of Compliance Personnel:

(a) Consistent with applicable System policies, the CCO shall assure the supervision, either directly or through assigned senior compliance personnel or other supervising Compliance and Privacy

[32] *See id.*
[33] *See* 63 Fed. Reg. 8987, 8997 § II(G)(1).

Officers, of the OCC's compliance personnel.

(b) Where appropriate, and as needed in the best interests of the Compliance Program, the CCO may reassign CPOs to perform compliance functions at different facilities and programs.

C. Corporate Compliance and Privacy Officers ("CPOs") of the OCC

(i) Executive and Senior CPOs shall be assigned to one or more System facilities or programs by the CCO, and are responsible for handling all compliance matters that arise from such facilities or programs, including conducting investigations and/or referring matters to other appropriate departments.

(ii) Executive and Senior CPOs are responsible for handling all HIPAA and other patient privacy issues that arise from their assigned facilities or programs, including conducting investigations, determining whether a beach of protected health information occurred, drafting breach notification letters when necessary, and providing counseling to Workforce Members who violate the System's HIPAA Privacy and Security Operating Procedures.

(iii) CPOs conduct periodic walkthroughs of their assigned facilities to assess compliance risks.

(iv) The First Deputy Corporate Compliance Officer and Deputy Corporate Compliance Officer(s) assist the CCO in the implementation of the Compliance Program, and other responsibilities of the CCO.

(v) CPOs conduct compliance and HIPAA training for Workforce Members and Business Partners, as appropriate and necessary, with the goal that:

(a) Workforce Members and Business Partners are aware of the Compliance Program's requirements; and

(b) Workforce Members and Business Partners have the requisite awareness, knowledge, and respect for pertinent standards of ethical and lawful conduct and that they meet these standards in the performance of their System duties and functions.

(vi) CPOs provide advice and guidance to the System facilities and/or departments to raise awareness of known or potential compliance vulnerabilities and risks, and to alert them to changes in relevant laws and regulations.

(vii) Under the oversight and direction of the CCO (or their designee), CPOs will have primary responsibility for, among other things:

(a) Reporting facility and program compliance activities to the CCO;

(b) Conducting periodic Risk Assessments at their facilities or programs and, with the CCO, selecting items resulting from the Risk Assessments for development of the System-wide Risk Assessments;

(c) Reviewing the periodic Work Plans, as well as fraud alerts, compliance program guidance, and publicly available enforcement or settlement actions issued by the U.S. Department of Health and Human Services Office of Inspector General ("OIG"), the State Office of the Medicaid Inspector General ("OMIG"), Centers for Medicare and Medicaid Services ("CMS"), Office for Civil Rights ("OCR"), and other regulatory and enforcement bodies to identify possible areas of System risk;

(d) Submitting reports to the CCO reflecting progress made in addressing items on the Work Plans;

(e) Scheduling the Compliance Committee meetings that correspond to their assigned facilities and/or programs over which they are charged with compliance oversight. Developing corresponding meeting agendas and minutes. All minutes shall be provided to the CCO;

(f) Reviewing, responding to, addressing, and, as necessary, investigating Compliance Helpline reports;

(g) Reviewing internal controls within their assigned facilities or programs to evaluate their efficacy in detecting and preventing significant instances or patterns of unethical, illegal, or improper conduct, and recommending to the CCO revisions of procedures as necessary to fulfill the obligations of the Compliance Program or as required by law; and

(h) Assisting the CCO with the Compliance Program implementation and other compliance oversight activities as designated or otherwise assigned.

D. Compliance Committees: The CCO shall ensure the establishment and operation of the compliance committees, including but not limited to the following:

(i) Enterprise Compliance Committee

(a) The Enterprise Compliance Committee ("ECC") is a standing committee that meets as needed, but in no event less than four times in a calendar year. The ECC is responsible for:

1) Developing and annually reviewing and updating the ECC Charter;

2) Discussing compliance issues, initiatives, and concerns;

3) Reviewing and finalizing the System's periodic Risk Assessments;

4) Developing Corporate Compliance Work Plans from the periodic Risk Assessments;

5) Ensuring that the System has effective systems and processes in place to identify compliance program risks, overpayments, and other issues, and effective policies and procedures for correcting and reporting such issues;

6) Ensuring that written policies and procedures and standards of conduct are current, accurate, and complete;

7) Coordinating with the CCO to ensure communication and cooperation by Covered Persons on compliance related issues, internal or external audits, and other requirements of the Compliance Program;

8) Advocating for the allocation of sufficient funding, resources, and staff for the CCO to fully perform their responsibilities;

9) Advocating for adoption and implementation of required modifications to the Compliance Program; and

10) Providing advice and guidance to the CCO on various compliance issues.

(b) The ECC reports to the President of NYC Health + Hospitals. The standing ECC members include the System's leadership in legal, financial, information systems, human resources, quality and safety,

facilities, post-acute care, materials management, internal audits, and risk management.

(c) In addition to the standing ECC members, the ECC shall include the following rotating members, who shall be selected by the President and serve two-year terms.
1) An acute care facility CEO; and
2) A long-term care/skilled nursing facility CEO.

(ii) Correctional Health Services Compliance Committee

(a) The Correctional Health Services ("CHS") Compliance Committee shall meet as needed, but in no event less than once per calendar year.

(b) The CHS Compliance Committee will be chaired by the CCO and the Senior Vice President for CHS, and should include leadership of CHS.

(iii) HHC ACO Inc. Compliance Committee

(a) The HHC ACO Inc. Compliance Committee shall meet as needed, but in no event less than once per calendar year.

(b) The HHC ACO, Inc. Compliance Committee is chaired by the CCO and the Senior Director of HHC ACO Inc., and shall include the Chief Executive Officer of HHC ACO Inc., the Medical Director of HHC ACO Inc., and other HHC ACO, Inc. personnel as needed.

(iv) Facility/Program Compliance Committees

(a) Each System facility and program, as defined by the CCO, must establish a Compliance Committee, which will be chaired by the CPO within the OCC assigned to provide compliance oversight activities to the facility or program.

(b) The Compliance Committees should include standing members appointed by the facility or program CEO(s) from the finance, quality, Health Information Management, human resources, risk management, clinical departments, Information Technology, and personnel from other departments as necessary and appropriate.

(c) The Compliance Committees will meet as needed but in no event less than two times a year.

IX. RESPONSIBILITIES OF ALL COVERED PERSONS

A. All Covered Persons are required to affirmatively participate in the Compliance Program, which includes, for example, the following:

(i) Conducting themselves in a manner that is ethical, legal, and consistent with the System's culture of compliance;

(ii) Reporting compliance issues and concerns to the OCC;

(iii) Refraining from engaging in retaliatory conduct as described in this OP;

(iv) Cooperating with internal investigations and audits;

(v) Adhering to the Standards of Conduct outlined in this OP;

(vi) Complying with this OP and applicable law;

(vii) Refraining from engaging in any of the Prohibited Acts outlined in this OP and the System's Principles of Professional Conduct ("POPC"); and

(viii) Protecting the confidentiality, privacy, and security of the System's confidential information (e.g., patient protected health information; the personally identifiable information and/or private information of Covered Persons, and System business information that is proprietary, protected under a legal privilege or applicable law, or is otherwise not subject to public disclosure), and refraining from accessing, disclosing, transmitting, or otherwise using the System's confidential information in a manner that is inconsistent with applicable law or the System's internal information governance policies or contractual requirements (e.g., business associate, qualified service organization agreements, and other contractual provisions that govern the use of confidential information).

X. EXCLUSIONS AND SANCTIONS SCREENING

A. NYC Health + Hospitals prohibits the employment, affiliation, contracting or volunteering of or with individuals or entities that are excluded from participation in any Federal or state health care program, are identified on the OIG's List of Excluded Individuals and Entities ("LEIE") or other similar Federal or State exclusion lists, are debarred or sanctioned by the General Services Administration ("GSA") System for Awards Management ("SAM"), or are excluded or sanctioned by the U.S. Department of the Treasury Office of Foreign Assets Control ("OFAC"), and those using a social security number of a deceased person identified

on the Social Security Administration's Death Master File ("SSDMF") or an inactive National Provider Identifier ("NPI") listed on CMS's National Plan and Provider Enumeration System ("NPPES").

B. Accordingly, the System conducts initial and periodic screenings of all Covered Persons and Vendors against such systems, lists, and databases. The CCO is responsible for developing and maintaining policies, procedures, and systems for the performance of such initial and periodic screenings, and monitoring of systems, lists, and databases (as required by law, guidance or industry best practice).

XI. ACCESS TO RECORDS AND FACILITIES

A. Unless otherwise prohibited by applicable law, the CCO and CPOs shall, to the extent that the CCO deems it necessary to carry out their compliance functions, duties, and obligations, be granted:

(i) Unimpeded entry to any area or location within the System; and

(ii) The authority to review documents and other information relevant to an investigation in consultation with the General Counsel, to the extent they are subject to legal privilege, including:[34]

(a) All documents and other information that are relevant to compliance activities, including, but not limited to, patient records, billing records, and records concerning the marketing efforts of the System and the System's arrangements with other parties, including employees, professionals, independent contractors, suppliers, agents, and physicians, etc.; and

(b) Any System device that creates, records, transmits or maintains potentially relevant information regarding a compliance initiative, report, complaint, investigation, audit, review, inquiry or assessment.

XII. EXECUTIVE ADMINISTRATIVE OVERSIGHT RESPONSIBILITIES

A. With regard to their administrative oversight duties and functions, all System Corporate Officers and Chief Executive Officers of System facilities and programs shall be responsible for, among other things, the following:

[34] *See* 63 Fed. Reg. 8987, 8994 § II(B)(1).

(i) Providing ethical leadership and establishing a culture of compliance, ethics, and integrity, and a tone from the top that demonstrates full support of the Compliance Program;[35]

(ii) Ensuring that all facilities, units and entities under their oversight operate, as applicable, in accordance with:

(a) The NYC Health + Hospitals' Principles of Professional Conduct ("POPC");

(b) This OP and other compliance policies and procedures, as well as all other System policies;

(c) All applicable Federal and State laws, rules and regulations; and

(d) All applicable Federal and State health care programs and private payor requirements.

(iii) Establishing and implementing directive, detective, preventive, and corrective internal controls, as well as corresponding systems, practices and procedures, to facilitate ethical and legal conduct;

(iv) Fairly and consistently enforcing, consistent with personnel rules and collective bargaining requirements and with the assistance of, and together with, Human Resources and Labor Relations, the System's disciplinary policies;

(v) Encouraging and supporting compliance reporting;

(vi) Mandating Workforce Member completion of System training programs;

(vii) Ensuring and facilitating the CCO's (and other compliance personnel) unaccompanied access to all facility Workforce Members as the CCO deems necessary to conduct internal investigations, audits, reviews and other compliance functions and activities relevant to the Compliance Program; and

(viii) Protecting whistleblowers by committing to a zero-tolerance policy when it comes to any retaliatory activity stemming from making reports of compliance concerns or participating in compliance investigations, reviews or audits.

[35] *See generally,* US Department of Justice Evaluation of Corporate Compliance Programs, Updated June 2020, page 10, at https://www.justice.gov/criminal-fraud/page/file/937501/download.

XIII. STANDARDS OF CONDUCT

A. Principles of Professional Conduct ("POPC")

All Covered Persons are required to adhere to the *NYC Health + Hospitals Principles of Professional Conduct* ("POPC"). The POPC is a guide that sets forth NYC Health + Hospitals' compliance expectations and commitment to comply with all applicable Federal and State laws. The POPC also describes the System's standards of professional conduct and efforts to prevent fraud, waste, and abuse.

B. Conflicts of Interests & Compliance with Related System Policies and Procedures:

All System employees or Workforce Members, as applicable, are required to comply with the System's OPs, including but not limited to the following:

(i) All System employees, Members of the NYC Health + Hospitals Board of Directors, and Directors of the System's wholly owned subsidiaries are required to adhere to Chapter 68 of the New York City Charter.

(ii) All non-employee Workforce Members and System affiliate employees (*e.g.*, SUNY Downstate, PAGNY, Mount Sinai, and NYU) are required to adhere to NYC Health + Hospitals' Code of Ethics.[36] Members of the System's Community Advisory Boards and Hospital Auxiliaries and other System-related personnel who are not covered by Chapter 68 must also comply with the Code of Ethics.[37]

(iii) All System employees shall comply with OP 20-55 (*Pharmaceutical Company Gifts and Sponsored Educational Programs*), which sets forth the obligations of these individuals as they relate to gifts from pharmaceutical and other companies that provide or intend to provide supplies and/or equipment to the System.[38]

---

[36] *See* NYC Health + Hospitals By-laws (the "By-laws") at Article XIX (Conflicts of Interest).
[37] *See id.* Note that, the NYC Health + Hospitals Code of Ethics may be accessed at: http://www.nychealthandhospitals.org/wp-content/uploads/2016/07/HHC-Code-of-Ethics-1.pdf.
[38] *See* OP 20-55 (Pharmaceutical Company Gifts and Sponsored Educational Programs). OP 20-55 may be accessed on the System's public webpage at: http://www.nychealthandhospitals.org/wp-content/uploads/2016/07/OP20-55.pdf.

By way of the System's Code of Ethics, all affiliate employees, members of the System's Community Advisory Boards and Hospital Auxiliaries, and other System-related personnel who are not directly covered under OP 20-55, are subject to the same restrictions outlined in OP 20-55.[39]

(iv) All Workforce Members shall comply with OP 50-3 (*Policy on Exchange and Receipt of Gifts*), which sets forth the System's policy on giving and receiving gifts.[40]

(v) All Workforce Members shall comply with OP 20-54 (*Nepotism*), which, with regard to Workforce Members who serve in a supervisory role or capacity at the System, sets forth the restrictions that Workforce Members are subject to as they relate to the supervision of relatives. OP 20-54 also prohibits two or more relatives who work in the same facility from working in the same unit regardless of whether a supervisory relationship exists.[41]

(vi) To the extent that OP 20-54 might not apply to Workforce Members who are not employed by the System, such Workforce Members shall comply with the nepotism provisions of the Code of Ethics.[42]

(vii) All Workforce Members shall comply with OP 20-61 (*Social Media Use*), which sets forth the System's policy on the use of social media.

(viii) All Workforce Members shall comply with OP 120-19 (Corporate Records Management Program).

(ix) All Workforce Members shall comply with HIPAA-related patient confidentiality policies and procedures in the 240 Series of NYC Health + Hospitals' Operating Procedures. [43]

(x) All Workforce Members shall comply with HIPAA security policies and procedures found in the 250 Series of NYC Health + Hospitals' Operating Procedures. [44]

---

[39] *See* OP 20-55 § 3(I); *see also* the System's By-laws at Article XIX (Conflicts of Interest).
[40] *See* OP 50-3 (Policy on Gift Exchange and Receipt).
[41] *See* OP 20-54 (Nepotism).
[42] See NYC Health + Hospitals Code of Ethics, § V.
[43] The 240 series of OPs are available on the System's intranet at: http://hhcinsider.nychhc.org/corpoffices/syswidePnP/Pages/Index.aspx.
[44] The 250 series of OPs are available on the System's intranet at: http://hhcinsider.nychhc.org/corpoffices/syswidePnP/Pages/Index.aspx.

(xi) All Workforce Members shall comply with the security policies found on the NYC Health + Hospitals Enterprise Information Technology Services ("EITS") security homepage, including but not limited to, policies that govern asset management, access control, and security incident response.

XIV. TRAINING AND EDUCATION

A. Policy

It is the policy of the System to communicate aspects of the Compliance Program and HIPAA regulations by providing effective compliance training and education programs (hereinafter "General Compliance/HIPAA Training") and otherwise disseminating information appropriate to the respective roles and responsibilities of affected Covered Persons.

B. Training Frequency

(i) All affected Covered Persons shall receive General Compliance/HIPAA Training as part of their orientation to the System, and thereafter receive further General Compliance/HIPAA Training on an annual basis.[45]

(ii) All Workforce Members who are granted access to any NYC Health + Hospitals electronic medical record or patient billing system shall complete the General Compliance/HIPAA Training prior to being granted access to such information systems, and every 12 months thereafter to maintain uninterrupted access to the such information systems.

(iii) Any Workforce Member who violates HIPAA and/or any System HIPAA Privacy or Security Operating Procedures shall be required to take HIPAA Remedial Training provided by the OCC upon discovery of such violation.

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

[45] *See* Social Services Law § 363-d(2)(c).

D. The CCO shall determine the content of training and education materials acceptable to meet the requirements of 18 NYCRR § 521-1.4(d). All compliance training and education materials shall be approved by the CCO.

E. All formal Training conducted throughout the System as part of the Compliance Program shall be documented and maintained by the OCC, and attendance of new hire and annual General Compliance/HIPAA Training shall be documented and tracked in PeopleSoft Enterprise Learning Management ("ELM") system.

XV. CONTRACT REQUIREMENTS

A. Policy Statement

Vendor contracts shall include terms consistent with the following:

(i) Vendors must require compliance with this OP and;

(ii) Vendors shall require compliance with NYC Health + Hospitals POPC; and

(iii) Contracts for Vendors that provide IT related functions shall require compliance with the Information Security Risk Management ("ISRM") Vendor Management Policy, and the Minimum Vendor Security Requirements.

B. Vendor Defined

For purposes of this OP the term "Vendor" means an individual or entity that provides, is available to provide or proposes to provide, goods or services to the System.

C. Vendor Selection Process

(i) The procurement of Vendors for goods and services shall comply with Operating Procedure 100-05.

(ii) As part of the vendor selection process, all vendors that create, receive, maintain or transmit PHI, electronic PHI ("ePHI") or other restricted confidential data will be subject to a security and compliance review.

D. Responsibilities

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

(i) The Office of Legal Affairs ("OLA") shall draft, negotiate or otherwise approve the contractual language necessary to meet the requirements set forth in subdivision "A" of this section.

(ii) The Office of Supply Chain shall establish internal systems, practices, procedures, and controls to ensure that all Vendor contracts meet the requirements set forth in subdivision "A" of this section, *supra*.

XVI. CORRECTIVE, REMEDIAL AND/OR DISCIPLINARY POLICY

A. The System is committed to:

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

(a) Encourage good faith participation in the Compliance Program by all Covered Persons, including, for example, policies and procedures that articulate expectations for reporting and resolving compliance issues and assisting in their resolution, and outline sanctions for:[46]

1. Failing to report suspected problems;
2. Participating in non-compliant behavior; or
3. Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior; and

(b) Prevent or reduce the likelihood of the reoccurrence of Prohibited Acts, as that term is defined in subdivision "C" of this section;

(ii) Applying appropriate sanctions against Covered Persons that fail to comply with applicable law and internal System policies and procedures;[47] and

(iii) Ensuring that System senior administrators, managers, and supervisors, as part of their work duties and functions, establish a work environment that encourages Compliance Reporting without fear of retaliation.

B. Overview

The failure by a Covered Person to comply with and/or affirmatively participate in the Compliance Program, or the engagement of a Covered Person in conduct that

[46] *See* Social Services Law § 363-d(2)(e); 18 NYCRR § 521-1.4(f).
[47] *See* Social Services Law § 363-d(2)(e) (disciplinary requirements under the State's mandatory provider compliance programs); 18 NYCRR § 521-1.4(f); *see also,* 63 Fed. Reg. 8987, 8995, § II(E)(1).

otherwise constitutes wrongdoing (collectively referred to as Prohibited Acts), may result in corrective, remedial and/or disciplinary actions.[48]

C. Prohibited Acts

The engagement of Prohibited Acts by a Covered Person will result in corrective, remedial, and/or disciplinary action. Prohibited Acts include any of the following:

(i) Failing to conduct themselves in a legally compliant and ethical manner;

(ii) Failing to report suspected compliance issues, problems, complaints, and incidents;[49]

(iii) Participating in non-compliant behavior, such as failing to comply with this OP or with any other applicable System OPs or other policy or procedure (*e.g.*, System privacy and security policies and procedures);[50]

(iv) Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;[51]

(v) Failing to comply with the POPC;

(vi) Failing to complete required training and education programs;

(vii) Failing to comply with applicable Federal and State laws (*e.g.*, engaging in criminal or unlawful/illegal conduct including conduct in violation of health care fraud, waste and abuse laws) and/or Federal health care program and private payer requirements;

(viii) Engaging in Retaliation, as that term is defined in subdivision "C" of § XIV against any person who reports (or threatens to report) actual or suspected Compliance Program violations or other Prohibited Acts;

(ix) Refusing to cooperate with an internal investigation, audit, review or inquiry;

(x) Failing to cooperate with government investigators or other regulatory enforcement bodies;

(xi) Failing to be truthful to internal or external investigators;

---

[48] *See, generally,* 63 Fed. Reg. 8987, 8995, § II(E)(1).
[49] *See* Social Services Law § 363-d(2)(e)(1).
[50] *See* Social Services Law § 363-d(2)(e)(2).
[51] *See* Social Services Law § 363-d(2)(e)(3).

(xii) Failing to report a matter to government officials or regulatory oversight agencies when required by Federal or State law to do so;

(xiii) Failing to preserve documentation and records relevant to internal or external investigations;

(xiv) Engaging in conduct that violates professional or clinical standards and/or obligations;

(xv) Furnishing care and services, and/or the creation or sanctioning of conditions, that potentially endanger patients, Workforce Members, or the public;

(xvi) Accessing, disclosing, transmitting, or otherwise using the following confidential System information in a manner that is inconsistent with Federal or State law or the System's internal privacy or security policies or contractual requirements (*e.g.*, HIPAA, business associate agreement, qualified service organization agreement, and other contractual provisions that govern the use of confidential information):

(a) Patient protected health information;
(b) The personally identifiable information and/or private information of Covered Persons; and/or
(c) System business information that is protected under legally recognizable privileges or applicable confidentiality laws, or is otherwise not subject to public disclosure;

(xvii) Failing to satisfy the responsibilities of all Covered Persons as outlined in subdivision "A" of § IX; and

(xviii) Engaging in any activity that has the potential to interfere with or otherwise negatively affect the policy objectives and purposes of the Compliance Program outlined in §§ I [**Policy**] and II [**Purpose**], respectively.

C. The Application of Corrective, Remedial, and/or Disciplinary Action

(i) Covered Persons may be subject to corrective, remedial, and/or disciplinary action up to and including termination of employment, contract or other affiliation with the System for engaging in Prohibited Acts.

(ii) Examples of actions that a Covered Person may face for engaging in a Prohibited Act may include, but are not limited to:

(a) Education, retraining or corrective coaching;

(b) Written warnings regarding the Prohibited Act;

(c) Counseling;[52]

(d) Written Reprimand;

(e) Financial penalties;[53]

(f) Demotion in grade or title;[54]

(g) Suspension without pay;[55]

(h) The revocation of privileges as provided under the applicable facility Medical Staff By-laws; and

(i) Termination of employment, contract or other affiliation with the System.[56]

(iii) Subject to personnel policies and collectively bargained provisions on employee discipline, corrective, remedial, and/or disciplinary action shall be enforced fairly and shall be applied consistently across the System to all Covered Persons regardless of rank, profession, title, duty or function.[57]

(iv) Subject to personnel policies and collectively bargained provisions on employee discipline, Workforce Member supervisors and/or managers can be held accountable for the foreseeable compliance failures of their subordinates.[58]

(v) Subject to personnel policies and collectively bargained provisions on employee discipline, each commission of a Prohibited Act must be considered on a case-by-case basis when determining the appropriate course of action that should be undertaken in response to such wrongdoing.[59] The

---

[52] *See* OP 20-10 (Employee Performance and Conduct), § IV(A), p.2.
[53] *See* 63 Fed. Reg. 8987, 8995-6, § II(E)(1); *see also* 65 Fed. Reg. 14289, 14303 (March 16, 2000); New York City Health and Hospitals Corporation, *Personnel Rules and Regulations,* Rule 7.5 [Discipline], § 7.5.5 (b).
[54] New York City Health and Hospitals Corporation, *Personnel Rules and Regulations,* Rule 7.5 [Discipline], § 7.5.5(d).
[55] *See* New York City Health and Hospitals Corporation, *Personnel Rules and Regulations,* Rule 7.5 [Discipline], § 7.5.5(c).
[56] *See* New York City Health and Hospitals Corporation, *Personnel Rules and Regulations,* Rule 7.5 [Discipline], § 7.5.5(e).
[57] *See* 63 Fed. Reg. 8987, 8996, § II(E)(1); *see also* 65 Fed. Reg. 14289, 14303.
[58] *See* 63 Fed. Reg. 8987, 8996, § II(E)(1).
[59] *See* 63 Fed. Reg. 8987, 8996, § II(E)(1); *see also* 65 Fed. Reg. 14289, 14303, § II(G).

nature and severity of the violation may be factors considered when corrective, remedial and/or disciplinary action is taken. [60]

(vi) Subject to personnel policies and collectively bargained provisions on employee discipline, when imposing corrective, remedial, and/or disciplinary action, a factor that may be considered is whether the Prohibited Act committed was part of a pattern or practice or an isolated incident. Another factor that may be considered is whether the Prohibited Act was intentional or unintentional.[61] For example, intentional or reckless noncompliance with applicable laws and internal policies, as well as noncompliance resulting from known conflicts of interests or from personal benefits gained by way of a Prohibited Act, is likely to result in significant corrective, remedial, and/or disciplinary action.[62] Other factors considered in imposing corrective, remedial, and/or disciplinary action may include instances in which a Covered Person commits a Prohibited Act that has affected or may affect:

(a) Patient, workplace, or environmental safety within the System (*e.g.*, conduct that amounts to patient abuse; the provision of clinical or other health services without an appropriate license where such a license is required by applicable law; intentional or reckless conduct that results (or has the potential to result) in serious injury or other harm to patients and/or Workforce Members; and the improper and unsafe disposal of toxic, hazardous, radioactive, and pharmacological agents, materials, instruments and supplies);

(b) The mission of the System to maintain a discrimination free patient care and work environment (*e.g.*, conduct involving the refusal to provide care, or the provision of substandard patient care, based on a patient's race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or any other protected characteristic covered by Federal, State or local anti-discrimination laws; or acts of discrimination in the workplace based on race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or any other protected characteristic covered by Federal, State or local anti-discrimination laws); or

(c) The integrity of the System's efforts to combat fraud, waste, abuse, theft, and corruption (*e.g.*, violations (or attempted violations)) of

[60] *See generally*, 63 Fed. Reg. 8987, 8995-8996, § II(E)(1).
[61] *See generally,* 63 Fed. Reg. 8987, 8995, § II(E)(1); 65 Fed. Reg. 14289, 14303, § II(G)(1).
[62] *See, generally,* 63 Fed. Reg, 8987, 8995, § II(E)(1).

fraud, waste and abuse, and theft and corruption laws including the submission of false claims and the failure to return identified overpayments; the concealment or cover up of a civil or criminal violation of law or internal policy or procedure; the falsification of official System business records including medical records, billing records, employment records, and financial records; the theft of System property; the acceptance or offering of bribes or kickbacks or the engagement of official misconduct or other corrupt activities; the engagement of conduct intended to thwart, stifle, suppress or otherwise interfere with an internal or external investigation into possible Compliance Program violations; and violations of the System's Non-Intimidation and Non-Retaliation Whistleblower Policy protections);

(vii) Any corrective, remedial, and/or disciplinary action taken against a Covered Person that engages in a Prohibited Act shall be in accordance with applicable Federal and State laws and, as appropriate, the terms, conditions, and other provisions found in all applicable documents governing the relationship or other affiliation between the System and a Covered Person (*e.g.*, employment contracts; vendor contracts; collective bargaining agreements; NYC Health + Hospitals Personnel Rules and Regulations and other System internal human resources and labor policies; affiliation arrangements; medical staff by-laws; or memoranda of understandings).

(viii) Where required by applicable law or internal policy, corrective, remedial and/or disciplinary action may trigger or include external reporting of certain misconduct to outside governmental entities including the Office of Professional Misconduct ("OPMC") and Office of Professional Discipline ("OPD").[63]

E. Implementation

(i) Where a compliance investigation (including matters investigated under the direction or at the request of the OCC) of a matter (or a matter that was investigated by another department that involved allegations of fraud, waste, and abuse; or theft or corruption, violations of information governance policies; conflicts of interests; conduct that could lead to the possible imposition of civil monetary penalties; violations of the human subject research policies and procedures; or other significant violations of the POPC) results in a substantiated finding of a commission of a Prohibited

[63] *See e.g.,* Public Health Law § 230(11)(a) and § 2803-e(1); *see also* 65 Fed. Reg. 14289, 14304.

Act by a Covered Person, the CCO (or their designee) shall refer the matter, as applicable to:

(a) Human Resources and/or Labor Relations with respect to employees;

(b) The Office of Affiliations, Human Resources, Office of Legal Affairs ("OLA"), and the corresponding facility CEO with respect to affiliate employees; or

(c) Supply Chain and OLA, and where necessary, Human Resources (*e.g.*, where a vendor provides Workforce Members to the System to carryout System activities), with regard to Vendors (except for affiliates).

(ii) Recommendations on corrective, remedial, and/or disciplinary action may be provided by the CCO to the Corporate or facility Chief Medical Officer, OLA, or the applicable Medical Staff Board President (or other individual authorized in the corresponding medical staff by-laws to receive and act on provider complaints) with respect to members of the medical staff who have engaged in a Prohibited Act.

(iii) Each matter involving the enforcement of disciplinary standards shall be documented by the individual or department imposing the disciplinary action.

(iv) The System's policy on corrective, remedial, and/or disciplinary actions shall be publicized and made readily accessible to all Covered Persons. [64]

XVII. MANDATORY COMPLIANCE

All Covered Persons are responsible for complying with:

A. This OP including, without limitation, the provisions found under § IX of this OP;

B. The POPC;

C. All applicable Federal and State laws; and

[64] *See generally,* 63 Fed. Reg. 8987, 8996.

D. All applicable Federal and state health care program requirements and conditions of participation, as well as applicable private payor requirements.

XVIII. MANDATORY REPORTING AND COMPLIANCE WITH INVESTIGATIONS

A. Mandatory Reporting

All Covered Persons have an affirmative obligation to report to the OCC (*see* reporting procedures outlined below in subdivision "B" of this section) the commission of (or any attempt to commit or conspiracy or other plan to commit) any Prohibited Act, as defined in this OP, violation of NYC Health + Hospitals' policies or Operating Procedures, or applicable laws and regulations, including privacy laws, that is brought to their attention or of which they otherwise become aware.

B. Reporting Procedure

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

NYC Health + Hospitals
Office of Corporate Compliance
50 Water Street, Suite 528
New York, NY 10004
Telephone: (646) 458-5632
Facsimile: (646) 458-5624
E-mail: COMPLIANCE@nychhc.org
Confidential Compliance Helpline:
1-866-HELP-HHC (1-866-435-7442)
MetroPlus Health Plan Compliance Hotline (for MetroPlus compliance issues)
1-888-245-7247

In addition to the reporting requirements noted above, Covered Persons can report suspected Medicare or Medicaid fraud, waste or abuse activities, or compliance concerns as follows:

By contacting CMS at 1-800- MEDICARE (1-800-644-4227)
By contacting the OIG at 1-800-HHS-TIPS (1-800-447-8477) or online by visiting https://forms.oig.hhs.gov/hotlineoperations/report-fraud-form.aspx or
By reporting directly to the Medicare or Medicaid plan sponsor.

C. Sanctions for Non-compliance

Failure to report a known violation, participate or cooperate with an investigation, be truthful with investigators, preserve documentation and/or records relevant to ongoing investigations, as well as participating in non-compliant behavior or encouraging, directing, facilitating or permitting non-compliant behavior, will result in corrective, remedial, and/or disciplinary action up to and including termination of employment, contract or other affiliation with the System as set forth in the Corrective, Remedial, and/or Disciplinary Policy in § XVI. Likewise, any Covered Person that attempts to interfere with or influence the outcome of a compliance investigation shall be subject to corrective, remedial, and/or disciplinary action.

XIX. RETALIATION PROHIBITED/WHISTLEBLOWER PROTECTION

A. Retaliation Prohibited/Whistleblower Protection

The System strictly prohibits intimidation and retaliation, in any form, against any Covered Person or other individual or entity that, in good faith, participates in the Compliance Program by reporting potential compliance issues and concerns and participating in the investigations of the same, or engaging in any of the activities identified in the System's Non-Intimidation and Non-Retaliation Whistleblower Policy (collectively referred to as "Protected Conduct"). Covered Persons should refer to the Non-Intimidation and Non-Retaliation Whistleblower Policy for additional information.

B. Whistleblower Defined

The term Whistleblower means any Covered Person that engages in Protected Conduct, or in good faith reports Prohibited Acts or other conduct that fails to comply with the requirements of the Compliance Program.

C. Retaliation Defined

The term Retaliation (or retaliatory conduct or action) is a negative action taken by any person or entity against an individual as a result of an individual performing a protected activity. Retaliatory actions include unwarranted discharges, demotions, suspensions, threats, harassment or discrimination, or any other adverse action imposed against any individual or entity as a consequence of any individual or entity's engagement in Protected Conduct or other participation in the Compliance Program.[65]

[65] *See* Labor Law §§ 741(1)(f), 740(1)(e).

XX. QUESTIONS REGARDING THE APPLICATION OF THIS POLICY

Any questions regarding the application or interpretation of this OP may be addressed to the OCC by phone, e-mail, facsimile, confidential compliance Helpline or mail as provided above in subdivision "B" of § XVIII.

XXI. APPLICABLE LAW PREVAILS

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

XXII. FUTURE POLICIES/DEVIATION FROM THIS POLICY

A. The CCO has the authority to create policies and procedures regarding the Compliance Program, subject to the approval of the President and Chief Executive Officer.

B. The creation of any other future policies or procedures regarding the Corporate Compliance and Ethics Program shall not supersede this OP unless the author of such policies and procedures has consulted with the CCO regarding the implementation of the same, and it is approved by the President and Chief Executive Officer.

C. Notwithstanding the provisions set forth above in subdivision "A" of this section, upon consultation with the CCO, the President of MetroPlus may, in their administration and implementation of this OP, approve and implement supplemental internal policies, procedures, and practices that are consistent with this OP and applicable Federal and State laws that govern health plans and insurance institutions as they deem necessary to fulfill MetroPlus' compliance obligations under applicable Federal and State laws.

XXIII. ONGOING REVIEW OF POLICY

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

A. Be the responsibility of the OCC;

B. Take place on periodic basis or as required by law, whichever is more frequent; and

C. Be documented in writing and maintained by the OCC.

XXIV. EFFECTIVE DATE

This OP shall become effective as of the date first written above and shall remain in effect until explicitly modified according to § XXII, *supra*, or suspended in writing by the President and Chief Executive Officer.