COMPLIANCE PROGRAM

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Table of Contents

A. Introduction ……...p. 3

B. Guiding Principles, Foundation and Governance …….. p. 4

I. Guiding Principles

II. Foundation of the Compliance Plan

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

a. Audit Committee

b. Finance Committee

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

C. Compliance Program Elements (Structure and Operations)……..……..p. 10

D. Compliance Procedures

E. Appendices

I. Code of Conduct ……..……..p. 21

II. Risk Assessment ……..……..p. 43

A. INTRODUCTION

UCHC Health System ("UCHC" or the "Corporation") is a Not-For-Profit Corporation created under the laws of the State of New York. The purposes and the mission of UCHC are to:[1]

- To operate one or more health centers, nursing homes, ambulatory care facilities and other health facilities for the treatment of the sick, injured, disabled and infirm, regardless of age, sex, sexual preference, race, color, nationality or creed, source of payment for their care or any other criteria not related to medical indications for admission and treatment, subject to the ability of the health center to provide such care;

- Where determined by the Corporation to be appropriate and feasible, to affiliate with, contract with, provide management and similar services to and receive such services from other health centers, nursing homes, ambulatory care facilities and other health facilities subject to applicable laws, rules and regulations;

- To carry on any educational and training activities, including medical or osteopathic school affiliation, related to rendering care o the sick, injured and disabled and to further practical knowledge in the science of medicine, which, in the opinion of the Board of Trustees, may be justified by the facilities, personnel, funds or other requirements that are, or can be made, available;

- To promote and carry on scientific and technological research related to the care of the sick, injured and disabled and related to the prevention of disease, so far as such research can, in the opinion of the Board of Trustees, be carried on in or in connection with the health center;

- To participate, as far as circumstances may warrant, in any activities designed and carried on to promote the general health of the community including, but not limited to, outreach programs, health education and referral services;

- To perform other acts, incidental to or connected with, the foregoing objectives, or in advancement thereof, consistent with the provisions of the Not-For-Profit Corporation Law of the State of New York, including, but not limited to acquiring by purchase or otherwise, land, buildings and equipment and receiving, collecting and holding either by gift, bequest or devise or otherwise, funds or property either real or personal and to use same in furtherance of the purposes of the Corporation.

- To be the health center of choice in the Bronx, with superior service and innovative programs that meet the diverse needs of our community.

[1] UCHC Bylaws Preamble, (as amended November 18, 2013) ; see also UCHC Public Website About Us, *Mission, Vision and Values* at http://www.UCHCny.org/index.php/about_us/mission-vision-and-values

- Union Community Health Center is committed to improving the health of our community and is dedicated to providing compassionate, comprehensive and innovative health care in a safe environment where the patient always comes first. All individuals will be provided complete, open and timely access to the highest quality of care, regardless of their ability to pay.

UCHC is committed to completing its purposes and mission while maintaining full compliance with all applicable laws, rules and regulations and ethical standards. UCHC is committed to providing its patients with high quality and caring medical services, but also to providing those services pursuant to the highest ethical, business, and legal standards. These high standards must apply to our interactions with everyone with whom we deal. This includes our co-workers, residents, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety. Personnel include UCHC Board Members, employees, affiliate employees, volunteers, and personnel.

We expect and require all personnel to be law-abiding, honest, trustworthy, and fair in all of their business dealings. To ensure that these expectations are met, the Compliance Program has become an integral part of our corporate mission and business operations.

The Corporate Compliance Plan, hereinafter "the Plan", outlines and explains the structural and operational elements of the UCHC Compliance Program and discusses some relevant laws, regulations, and policies and procedures. The Plan, which will be amended and updated according to any changes to applicable laws and regulations, is distinct from the Compliance work plan ("work plan"), which is prepared bi-annually.

B. GUIDING PRINCIPLES, FOUNDATION AND GOVERNANCE

I. Guiding Principles

The Board of Trustees ("Board") at UCHC, along with Executive leadership, has long recognized the importance of having a robust infrastructure to address the ever growing complexities of compliance issues found in the healthcare industry. Besides "address[ing] the public and private sectors' mutual goals of reducing fraud and abuse', the success of the compliance program can lead to enhanced healthcare operations, improved quality of care, and a reduction of healthcare costs.[2] There are many benefits of an effective compliance program, including the following:[3]

- Demonstrating [UCHC's] commitment to honest and responsible corporate conduct

[2] 70 Fed.Reg. 4858, 4859 Department of Health and Human Services Office Of the Inspector General OIG Supplemental Compliance Program Guidance for health centers (2005)
[3] Id.

- Increasing the likelihood of preventing, identifying and correcting unlawful and unethical behavior at an early stage
- Encouraging personnel to report potential problems to allow for appropriate internal inquiry and corrective action, and
- Through early detection and reporting, minimizing any financial loss to government and taxpayers, as well as any corresponding financial loss to the health center.

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

The goal of UCHC's Compliance Program is to establish standards and procedures to: 1) prevent and detect criminal conduct, fraud, waste and abuse;[4] 2) to foster an UCHC environment that encourages ethical behavior and adherence to the law and ethical business practices; and, 3) to create a system of checks and balances designed "to prevent inaccurate billing and inappropriate practices in the Medicaid [and Medicare] program[s]."[5]

II. Foundation of Compliance Program

The Compliance Program is modeled after the requirements found in the Department of Social Service's mandatory compliance program regulations.[6] In addition, the Compliance Program adopts the principles set forth in the 2010 Federal Sentencing Guidelines that cover effective compliance and ethics programs.[7] Likewise, the Plan follows the guidance related to compliance provided by the Department of Health and Human Services Office of Inspector General's 1998 *Publication of the OIG Compliance Program Guidance for health centers* and its corresponding supplement, *OIG Supplemental Compliance Program Guidance for health centers*, issued in 2005, as well as other OIG guidance.[8]

UCHC's Compliance Plan is the roadmap to a comprehensive compliance program, which applies to many important compliance areas including, but not limited to, "billings, payments, medical necessity and quality of care, governance, mandatory reporting, credential and other risk areas", that are discovered through compliance activities.[9]

The Compliance Program is comprised of the eight elements that are set forth in the Department of Social Services regulations that describe mandatory compliance programs and fulfills the

[4] Federal Sentencing Guidelines section 8B2.1 (a)(1)
[5] Office of the Medicaid Inspector General, Mandatory Compliance Programs, Frequently Asked Questions: What is the Purpose and intent of the Mandatory Compliance Law?
[6] 18 N.Y.C.R.R. Part 521
[7] 2010 Federal Sentencing Guidelines Section 8B2.1
[8] Department of Health & Human Services (HHS) Office of the Inspector General (OIG) Publication of the OIG Compliance Program Compliance for health centers (1998), see also 70 FR 4858 HHS OIG, OIG Supplemental Compliance Program Guidance for health centers (2005)
[9] 18 N.Y.C.R.R. Section 521.3 [a] [1-7]

requirements of an effective compliance and ethics program found in the 2010 Federal Sentencing Guidelines. In summary, these elements and requirements are:[10]

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

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

The Board is UCHC's governing body. The Board is responsible to "establish, cause to be implemented, maintain, and as necessary, revise its practices, policies and procedures for the ongoing evaluation of the services operated or delivered by the health center and for the identification, assessment and resolution of issues that may develop in the conduct of the health center."[11]

With regard to compliance, the Board is responsible to:

"Take all appropriate and necessary actions to monitor and restore compliance when deficiencies in the health center's compliance with statutory and/or regulatory requirements are identified, including, but not limited to, monitoring the President's submission and implementation of all plans of correction."[12]

In the 2011 Medicaid Work Plan, it was reported that the "OMIG is and will be conducting investigations of significant compliance failures to determine the potential governess weakness, and to determine appropriate action, including possible censure and exclusion of board members."[13]

In addition to the appointment of a Compliance Officer, UCHC, through its bylaws, has also established Standing and Special Committees of the Board that serve key roles in UCHC meeting its external and internal compliance requirements. These committees include the Compliance Committee and the Finance Committee.

[10] Id. At section 521.3 [c] [1-8]
[11] Union Community Health Center Bylaws, Section 1.12(a)
[12] Union Community Health Center Bylaws, Section 1.12(h)
[13] NYS OMIG 2010-2011 Workplan, *The Focus on Governance and its Relationship to the Compliance Function, p.5*

1. Compliance Committee

The Compliance Committee is a standing committee of the Board and is comprised of Board members. The Committee is tasked with reviewing reports and recommendations, is to advise and assist the Compliance Officer with implementation of the Compliance Plan.

2. Finance Committee

The Finance Committee is a standing committee of the Board and is comprised of Board members. The Committee is responsible for supervising the management of all the endowment and trust funds of the health center. It shall arrange for all endowment and trust funds to be properly invested and the assets to be held for safe-keeping with one or more trust companies or banks duly authorized to conduct such business in the state. It shall require prompt reports concerning such investments and the income therefrom.

The Finance Committee shall cause to be prepared and shall submit to the Board of Trustees at the January meeting of the Board a budget showing the expected receipts, income and expenses for the ensuing year. It shall be the further duty of the Finance Committee to examine the monthly financial reports. Minutes of the Finance Committee meetings shall be submitted to the Board and its actions shall be subject to approval or disapproval at the next regular Board meeting. The Finance Committee shall review periodically personnel policies and the Wage and Salary Program and will recommend to the Board the compensation to be paid to the Chief Executive Officer.

IV. Governance: Responsibility of the Board as Governing Body under Medicare, Medicaid, and Department of Health Regulations:[14]

The Board, as governing body of each UCHC facility, is responsible for the quality of care, health center obligations, and legal compliance; health center organization and operation; health center compliance with federal, State and local laws; appointing a chief executive officer; determining medical staff eligibility, ensuring the implementation of patient care practices; providing an appropriate physical plant; services performed under health center services contracts, developing an institutional plan and budget; and the provision of emergency services. Below are these requirements.[15]

1. In order to achieve and maintain generally accepted standards of professional practice and patient care services in the health center, establish, cause to be implemented, maintain, and as necessary, revise its practices, policies and procedures for the ongoing evaluation of the services operated or delivered by the health center and for the identification, assessment and resolution of problems that may develop in the conduct of the health center. The Board shall ensure that material policies and procedures shall be reviewed regularly and revised as necessary by collaboration of appropriate health center

[14] Generally, responsibilities of the Governing Body under Department of Health regulations and Medicare/Medicaid regulations may be found at 10 NYCRR §405.2 and 42 CFR §482.12, respectively.
[15] Union Community Health Center Bylaws, Article VI, §1.12

or medical staff. The Board shall provide for the collaboration of health center leaders in developing, rendering and revising such policies and procedures.

2. Establish and maintain a coordinated quality assurance program which integrates the review activities of all health center services for the purpose of enhancing the quality of patient care and identifying and preventing medical, dental and podiatric malpractice.

3. Review the patient care activities of the Medical Staff through the health center's quality assurance program and the activities of the Medical Director and take prompt action where necessary to protect the quality of patient care and ensure that patients with the same conditions receive the same level of care.

4. Ensure that at least one (1) member of the Board of Trustees, who is not otherwise affiliated with the health center, shall serve on the Medical Staff's quality assurance committee and shall report on the activities of such committee at each meeting of the Board of Trustees.

5. Review and approve the health center's long range and quality assurance plans which shall specify the responsibility of each level of the organization with regard to such institutional planning and quality assurance activities.

6. Provide a safe physical plant equipped and properly staffed to maintain fit and adequate facilities and services for health center patients, and participate in planning for the health center's growth and development.

7. Participate in orientation and continuing education programs addressing the mission of the health center, roles and responsibilities, patients' rights, and the organization, goals and operation of the health center's qualify assurance program.

8. Take all appropriate and necessary actions to monitor and restore compliance when deficiencies in the health center's compliance with statutory and/or regulatory requirements are identified, including, but not limited to, monitoring the President's submission and implementation of all plans of correction.

9. At the annual and regular meetings of the Board of Trustees, evaluate the conduct of the health center, including patient care quality issues and the performance of the Board of Trustees.

10. Appoint a Chief Executive Officer who is responsible to the Board of Trustees for the management of the health center and assure the Chief Executive Officer's effective performance through ongoing documented monitoring and evaluation of that performance against written criteria developed for the position including the health center's compliance with statutory and regulatory requirements, the corrective actions required and taken to achieve such compliance, and the maintenance of corrective actions to achieve continued compliance in previously deficient areas.

11. After consultation with the Medical Staff, appoint a physician as Medical Director who is qualified for membership on the Medical Staff and who shall be responsible for directing the Medical Staff organization.

12. Organize the physicians, dentists and appropriate other persons granted privileges in the health center into a Medical Staff under medical Staff Bylaws approved by the Board.

13. Require health center leaders (including Board members, Senior Administration, Medical Staff Officers and Department Directors and Nurse Directors) to undertake education about continuous quality improvement and ensuring that a program of continuous quality improvement is developed and policies and procedures established in support of continuous quality improvement. In addition, the Board of Trustees shall ensure systematic and effective communication between the Board and the health center leaders and among health center leaders as well.

14. Develop and review at least annually and amending as necessary an organizational mission statement; soliciting community views in connection therewith; demonstrating the health center's operation al financial commitment to meeting community health care needs; provide charity care service and improve access to services by the underserved and generally acting in accordance with requirements for community service plans under the Public Health Law. The Board shall ensure prompt resolution of any conflict among health center leaders and the individuals under their leadership by ensuring compliance with the systems in place for resolving such conflicts.

15. Ensure that the Medical Director coordinates, oversees, reports and recommends action and follow-up on all quality assurance responsibilities given to the Medical Staff by the Board of Trustees pursuant to applicable law and consistent with the health center's Quality Assurance Plan.

16. Ensure that, through appropriate frameworks, the health center leaders establish healthcare services that respond to community and patient needs. health center leaders shall be expected to collaborate on planning and designing services, directing services, integrating and coordinating services and improving performance.

17. Provide a system for resolving conflicts among leaders and individuals under their leadership.

18. Approve the process for credentialing, recredentialing and privileging of physician assistants and advanced practice nurses (e.g. nurse practitioners) and other allied health professionals who are not considered to be members of the Medical Staff.

C. COMPLIANCE PROGRAM ELEMENTS

1. Written Policies and Procedures

To clearly state its compliance expectations and to describe the Compliance Program and its approach to compliance, UCHC has enacted several policies and procedures guiding various aspects of our business that are regularly reviewed and updated. Every personnel or other individual associated with the UCHC shall be familiar with the relevant policies and procedures necessary for job performance and updates will be provided on a timely basis.

a. UCHC's Code of Conduct

UCHC has adopted as part of the Compliance Program, a Code of Conduct (Appendix A) which outlines standards of conduct for personnel' in the workplace and in any activity where personnel's actions reflect on UCHC. Every member of personnel, volunteer, contracted practitioner or other agent of the UCHC shall be familiar with its contents and adhere to its code and standards. While a person's duties will vary depending upon his or her position within the UCHC, all individuals associated with the UCHC are held to the same legal and ethical standards discussed herein. It is the responsibility of all persons associated with UCHC to understand, implement and uphold the standards set out in this Plan, the Code of Conduct and the UCHC's policies and procedures. UCHC expects that its personnel will adhere to this Compliance Plan. UCHC's compliance standards will also be incorporated into all contracts entered into with all business associates, contracted practitioners and vendors.

Union Community Health Center is committed not only to providing patients with high quality and caring medical services, but also to providing those services pursuant to the highest ethical, business, and legal standards. These high standards must apply to our interactions with everyone with whom we deal. This includes our patients, other health care providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety.

In short, we do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the health center. We expect and require all personnel to be law-abiding, honest, trustworthy, and fair in all of their business dealings. To ensure that these expectations are met, the Compliance Program has become an integral part of our corporate mission and business operations.

The Compliance Program's Code of Conduct provides guidance to ensure that all of our work is done in an ethical and legal manner. Adherence to its spirit, as well as its specific provisions, is absolutely critical to our future. Personnel are advised to raise the issue with your supervisor, with a member of the Compliance Staff at the numbers listed in the last section of the Code of Conduct, or over the Compliance Hotline. It is a basic principle of our Compliance Program that there will be no retribution for asking questions, raising concerns about the Code, or reporting possibly improper conduct.

b. Conflicts of Interest

UCHC has a conflicts of interest policy that requires all personnel to disclose to the Compliance Officer any conflicts of interest in outside companies, entities or concerns. Conflicting interests

can include both financial interests and non-financial relationships with entities that compete or do business with the health center, and include any interests that otherwise could create an appearance that the personnel's conduct on behalf of the health center might be compromised in some way by the competing interest. Conflicts must be reported even if the conflict arises because only an immediate family member has the interest in the other entity. All UCHC Board members are subject to the conflict of interest policy which states "all Trustees and Officers of the health center [shall] avoid any conflict between their own interests and the interests of the health center in dealing with suppliers, customers and all other organizations or individuals doing or seeking to do business with the health center"[16]

c. Gift Policy

UCHC personnel may not accept gifts and health centerity from patients, patients' family members, vendors, vendors or contractors doing business with the health center if doing so would create an appearance that the gift or health centerity is being provided to induce the workforce member to act in his or her own benefit (over the health center's). *Cash may not be accepted under any circumstances*. Personnel may accept business entertainment consistent with what is reasonable under the circumstances, as long as the offered entertainment is not for the purpose of improperly influencing the workforce member's business behavior. Items of nominal value such as holiday cookies or candy that are tokens of appreciation may be accepted.

d. Health Insurance Portability and Accountability Act

UCHC's efforts at ensuring compliance with the Health Insurance Portability and Accountability Act ("HIPAA") are managed by the Compliance Officer, who is the designated HIPAA Privacy Officer, and in cooperation with the HIPAA Security Officer. The Compliance Officer's primary responsibilities include:

i. Ensuring that UCHC is compliance with applicable federal and state laws and regulations pertaining to the privacy of protected health information ("PHI");
ii. Developing and implementing corporate HIPAA privacy policies and procedures:
iii. Developing and/or implementing corporate-wide HIPAA privacy awareness training programs.
iv. Tracking and coordinating the investigation of HIPAA privacy violations and breaches of PHI, whether in oral, paper or electronic ("EPHI") format:
v. Mitigating the effects of privacy violations and security breaches, and providing required notice to affected parties and governmental organizations; and,
vi. Serving as UCHC's designated liaison to regulatory and accrediting bodies on matters related to health privacy.

1. *Privacy Procedures*

- Notice of Privacy Practices ("NPP")

[16] Union Community Health Center, Article X, §10.01

UCHC provides copies of the NPP to all patients and/or patients' personal representatives during their initial encounter, and upon request. All UCHC facilities are required to prominently post a copy of the NPP in key registration and admission areas. Registration and/or Admitting staff is required to make a good faith effort to secure the patient's or patients' personal representatives' written acknowledgement that the patient received the NPP. The NPP is also available via UCHC's internet website[17] and the intranet site.

- Patient's Access to PHI

UCHC has implemented procedures that permit a patient or a patient's personal representative to request access to inspect and/or obtain a copy of his or her designated record set[18] held by each facility or its business associates, for as long as the PHI is maintained in the record set.

- Disclosures of PHI

UCHC makes reasonable efforts to safeguard PHI. UCHC may use and disclose PHI without authorization for treatment, payment and healthcare operations. UCHC shall not otherwise use such individual's PHI without that individual's explicit authorization. UCHC shall disclose PHI only upon authorization by the patient or patient's personal representative, unless as otherwise specifically permitted by state or federal law. [19]

- HIPAA Privacy Self Assessment

Self-directed HIPAA Privacy Assessments ("Assessment") are conducted at least annually. The purpose of the assessment is to evaluate compliance with the standards set forth in UCHC's Privacy Policies and Procedures, to provide a gauge or benchmark for performance and to implement corrective action plans as necessary. The Compliance Officer is responsible for conducting and/or overseeing the Assessment.

2. *HIPAA Violations*

When there is an issue, pursuant to the HIPAA Privacy Rule and UCHC policy, UCHC has provided a process for privacy complaint to be filed, tracked, investigated and resolved. Complaints may be made by filing a written complaint or via the UCHC Privacy Hotline (1-718-960-5577). All complaints are tracked. When personnel are determined to have violated UCHC HIPAA policies and procedures, the Compliance Officer works with Human Resources to ensure that an appropriate sanction is imposed.

3. *Breach Notifications*

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

[17] http://www.uchcbronx.org/
[18] UCHC Policy ~ "HIPAA - Access to Patient Information & Right to Amend Patient Records," September 2012.
[19] UCHC Policy ~"Confidentiality of Patient Information," November 2012.

individuals.[20] The Compliance Officer coordinates the tracking and investigation of potential HIPAA breaches. Once it is determined by Counsel that, as a matter of law, a HIPAA breach has occurred the Compliance Officer administers the process of notification. The notification process includes drafting a written notice subject to Counsel's approval and coordinating the printing and mailing of the notice in a reasonable period not greater than sixty days from discovery of the breach.

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

4. *Business Associates ("BAs")*

UCHC meets the HIPAA requirement regarding the disclosure of patient PHI to BAs, and the creation or receipt of PHI by BAs, by having third-party vendors and service providers execute a business associate agreement ("BAA"). The BAA is a vehicle for UCHC to obtain adequate assurances the BAs will appropriately safeguard PHI and immediately inform UCHC of any privacy violations and breaches of PHI in connection with their service on behalf of UCHC.

5. *UCHC Research Policy and Guidelines*

The Institutional Review Board ("IRB") is tasked with implementing, administering and overseeing the activities pertaining to human subject research operations at UCHC. Its primary responsibility is to ensure that the rights and welfare of UCHC's patients who volunteer as research participants are protected as per State and Federal laws, rules, codes, and regulations[21] as well as internal policies and procedures. The IRB is responsible for, in pertinent part, the following: (i) following written procedures that govern, "its initial and continuing review of research…; (ii) for determining which projects require review more than annually….; and, (iii) for ensuring prompt reporting to the IRB of proposed changes in a research activity…."[22] The IRB is also responsible for, among a host of other obligations, "ensuring prompt reporting to the IRB, appropriate [UCHC] officials…of (i) any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with [45 CFR part 46] or the determinations of the IRB; and, (ii) any suspension or termination of IRB approval.[23]

UCHC has undertaken to develop and implement a health center-wide plan designed to achieve compliance within UCHC's policies and with all applicable requirements of HIPAA, (Health Insurance Portability and Accountability Act of 1996) and its related regulations including any

[20] The Compliance Officer also provides notice to affected parties pursuant to New York General Business Law §899-a when it is determined that private information has been compromised.

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

[22] 45 CFR §46.103[b][4], 46.108[a]

[23] 45 CFR §46.103[b][5], 46.108[a]

and all requirements regarding the privacy and security of health information. In connection with the implementation of the HIPAA Compliance Plan, the IRB of UCHC has been charged with ensuring that all human research projects conducted or proposed by UCHC are conducted in compliance with HIPAA. The IRB has, therefore, developed and will implement this Policy for the application of HIPAA to all research activities. This Policy is designed to ensure that any such research conducted by UCHC will be conducted in full compliance with HIPAA.[24]

6. *Record Retention/Destruction*

UCHC personnel and affiliates are expected to comply fully with the records retention and destruction policy for the department in which they work. If UCHC personnel and affiliates believe that documents should be saved beyond the applicable retention period, their supervisor should be consulted. There are criminal penalties for any person who knowingly alters, destroys, mutilates, or conceals a document with the intent to obstruct justice or influence an official investigation or proceeding.

2. Designation of a Compliance Officer and Compliance Committee

a. Compliance Officer

In order to uphold our values and monitor compliance with the Plan, Code of Conduct and policies and procedures, UCHC will select a Compliance Officer. The Compliance Officer is responsible for:

i. Maintaining a reporting system and respond to concerns, complaints and questions related to the Compliance Plan;
ii. Developing and implement compliance policies and procedures and oversee and ensure adherence to the Compliance Plan;
iii. Actively seek and research current material relative to regulatory compliance;
iv. Collaborating with the training department to develop and implement a program for communicating the requirements of the Compliance Plan to the UCHC's personnel, contracted practitioners and board members;
v. Periodically update the Compliance Plan to reflect changes that may occur with UCHC, pertinent laws and regulations, and mandates of governmental and other relevant third party payers;
vi. Ensuring that training is updated at regular intervals to include new developments in the law;
vii. Advising and monitoring departments to assure conformity with the Plan;
viii. Scheduling, conducting and monitoring internal audits and monitor external audits;
ix. Identifying and investigating areas of non-compliance;
x. Implementing corrective action plans in conjunction with management;
xi. Ensuring that corrective action has been implemented; and,
xii. Maintaining records of all corrective actions and investigations.

[24] "HIPAA-9 Use of Patient Information in the Conduct of Research Activities," December 2008.

b. Reporting

The Compliance Officer has direct lines of communication as needed to the Chief Executive Officer, Senior Administration, the Board of Trustees and legal counsel. The Compliance Officer shall report directly to the UCHC's Senior Administration and shall report at least quarterly to the Board of Trustees on the activities of the Compliance Plan.

c. Office of Patient Safety

UCHC's Office of Patient Safety ("OPS") is led by its Patient Safety Officer who serves as the organizational spokesperson for patient safety issues. The OPS is tasked with organizing, directing and coordinating activities to insure the promotion of UCHC Health System patient safety policies and programs. It oversees the collection and dispersion of information related to patient safety through monitoring and reporting performance relative to patient safety indicators, collaborates with clinical staff to develop, implement, monitor and champion performance improvement processes and policies related to key patient safety issues, coordinates efforts of various departments / stakeholders related to patient safety; shares the experience/learning with others through professional presentations, publications, etc., initiates actions to reduce patient risk exposures, and identify and analyze near misses, adverse occurrences and sentinel events.

3. An Effective Training and Education Program for Personnel

A key element of the UCHC compliance plan is that all relevant employees, affiliates and the Board receive compliance training and education covering compliance issues, expectations of employees in creating an environment of compliance, and the operation of the UCHC compliance program. The Compliance Program develops appropriate methods to ensure that all appropriate personnel receive training and education. All reputable and relevant materials, including videos and other materials from industry publications and related entities will be considered. Written material, such as a Code of Conduct, and policies and procedures will be available to all personnel.

UCHC will communicate its expectations and policies and procedures to its personnel through a required orientation program and publication of this Plan. The orientation program is a formalized training and education program. New workforce member orientation and education is provided to personnel upon employment and includes education on compliance, including HIPAA, safety, infection control, harassment/discrimination, and quality assurance. All employees shall receive annual education on the Deficit Reduction Act and Fraud, Waste, and Abuse Prevention guidance. Computer-based training ("CBT") on Fraud, Waste and Abuse is required for all personnel. Training shall be documented by electronic and manual means where applicable.

Consistent with the responsibilities described for the Compliance Officer, UCHC will provide training opportunities for compliance staff to stay current about compliance guidance, changes to

applicable laws and best practices in the compliance profession; and, to obtain and maintain the Health Care Compliance Association's Board Certification in Health Care Compliance ("Certification").

UCHC has a compliance website that can be accessed at http://UCHCwiki/wiki/CorporateCompliance/WebHome, and which is maintained by the Compliance Officer. This website provides materials for the reference of all staff, and provides around-the-clock access to compliance policies and procedures, information about the compliance program, and guidance on how to report potential compliance issues.

Every workforce member, contracted practitioner and member of the Board must sign and return the acknowledgement form, which states that the individual has read and understands these provisions. Each workforce member, will be required to annually review these compliance standards and sign and return a new acknowledgement form. All personnel will receive copies of any changes in these policies as they occur and receive updated training as necessary.

4. A Confidential Reporting System and Open Lines of Communication

All personnel, including Senior Administration, shall acknowledge in writing their responsibility to immediately report any known or suspected instances of non-compliance with this Plan, including but not limited to fraud, waste or abuse.

To maximize the opportunity for personnel to report these issues, UCHC is committed to establishing and maintaining communication lines to the Compliance Officer and ensuring that communication is available to all personnel associated with the health center, executives, and the Board.

If for any reason a workforce member or other individual associated with the UCHC does not wish to report a violation to a direct supervisor, he or she may contact the Compliance Officer. Reports to the Compliance Officer can be made anonymously via telephone or voicemail to a secure hotline (718-960-3705). Written reports can be submitted by fax, U.S. mail, or interoffice mail. All communications of this nature will be investigated thoroughly and fairly and will be kept, to the extent possible, in the strictest confidence.

UCHC will ensure the confidentiality of its records at all levels. Reports may be made without fear of retaliation, retribution, or breach of confidentiality. Strict rules on privacy and confidentiality of information will be mandatory with restriction on the flow of information to those who need to know for investigative purposes. We will operate under the presumption of innocence with safeguard for the rights of the accused.

Retaliation or intimidation of any sort against a workforce member or other individual associated with UCHC for reporting an incident in good faith or against a workforce member/s or other individuals who participate in an investigation will not be tolerated. Failure to report noncompliance, failure to cooperate with an investigation, or knowingly making a false report will be grounds for disciplinary action, up to and including termination of employment or other association with the UCHC.

The Compliance Officer employs a systematic procedure for documentation and tracking all concerns reported. The procedure ensures that all compliance contacts, including but not limited to, letters, emails, in person compliance, hotline calls and other departmental referrals are documented in the Compliance Database. The database is maintained by the Compliance Officer and is tracked for timeliness of action and ultimate resolution.

5. Internal Monitoring, Auditing and Review

UCHC will perform periodic, unannounced compliance audits by staff who have familiarity with the applicable Federal, State and local statutes, regulations and program requirements. We will also fully cooperate with external auditors and will contract for audits with outside firms as needed.

As outlined in 18 NYCRR section 521.3-Compliance Program required Provider Duties, UCHC is required to have a compliance program which has "a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluation and audits, credentialing, and quality of care of medical assistance program beneficiaries."[25]

The Risk Assessment is a component of UCHC's Compliance Program. The Compliance Officer is responsible for implementing, overseeing, and monitoring the Program which is centered on promoting the prevention, detection and correction of fraud, waste, and abuse, as well as any other unprofessional or criminal conduct; and ensuring UCHC's compliance with City, State and Federal laws, rules, and regulations, and its own business and ethical standards of practice. This includes a review of pre-defined lists of risk areas identified by, among other authorities, the U.S. Department of Health and Human Services ("HHS") Office of the Inspector General ("OIG"), the New York State Department of Health ("DOH") Office of the Medicaid Inspector General ("OMIG"), as well as reviews of external and internal audits. It will also include a survey tool to be used by key UCHC personnel who will assist in identifying risk.

The Risk Assessment is undertaken in furtherance of New York State Social Services Law §363-D(2)(F) and Regulation 18 N.Y.C.R.R. §521.3(c)(6), which require the establishment of "a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of [Medicaid] beneficiaries."[26] UCHC's risk assessment process is detailed in Attachment B.

UCHC has various sub committees which monitor, audit and report to the Board of Trustees, these are detailed in Attachment C and include the Executive Quality Assurance and Performance Improvement, Patient Safety, Engineering, Internal Review Board and Infection Control Committees.

[25] 18 N.Y.C.R.R. part 521.3(c)6
[26] 18 NYCRR § 521.3(c)(6)

6. **Enforcement of Publicized Standards and Disciplinary Guidelines**

While all instances of noncompliance cannot be foreseen, there are several key steps UCHC will take to try to prevent legal and ethical violations and enforce the standard described in this Plan:

a) UCHC shall conduct reasonable inquiries into the background of all prospective personnel, prior to hiring, contracting with or appointing the individual.

b) UCHC shall make compliance with this Corporate Compliance Plan and applicable laws and regulations a condition of employment at or other association with UCHC.

c) UCHC shall take appropriate action in response to failure to comply with this Plan and such failure will be documented in the workforce member's file.

- UCHC requires all personnel, including executives, executive assistants, the chief financial officer, department heads, contracted practitioners, members of the Board and any other person in a policy-making position to timely disclose to UCHC any activities which do not comply with regulatory standards including conviction of any crime.

- UCHC will sanction directors, managers and supervisors for failure to adequately instruct their subordinates in the requirements of this Plan or for failing to detect non-compliance with applicable policies and legal requirements where reasonable diligence on the part of the director, manager or supervisor would have led to the earlier discovery of any issues or violations.

- UCHC requires all directors, managers and supervisors to encourage and support the commitment and adherence to the policy and procedures of the Compliance Plan.

- UCHC requires all directors, managers, supervisors and personnel to immediately notify the Chief Operating Officer in the event of any visits, audits, investigations or surveys by Federal of State agencies or authorities, and forward correspondence received from any regulatory UCHC charged with administering a Federal or State funded program or enforcing its relevant regulations.

7. Timely Response to Detected Offenses and Development of a Corrective Action Plan

UCHC shall take all necessary steps to respond to every allegation of noncompliance or violation of this Plan. If it determines that a violation has occurred, an inquiry into the matter will be undertaken. All reasonable measures will be taken to maintain the confidentiality of such inquiries.

If UCHC determines that a violation of this Plan has occurred, whether through monitoring, an anonymous tip, internal investigation, audit or other means, there are a series of

corrective steps UCHC may take depending upon the severity of the violation. Such responses will serve two purposes: first, to correct the violation, and second, to prevent further similar violations. Corrective steps may include: revision of or implementation of new policies and procedures, refunding overpayments, training or re-training, written warnings, and/or suspension or termination of persons associated with UCHC. All corrective actions will be determined on a case-by-case basis and may include disciplinary action up to and including termination of employment or other association with the UCHC. Counsel shall be contacted as needed.

8. Protection of Whistleblowers and protection against Retaliation

UCHC strictly prohibits initiation or retaliation in any form, against any individual who, in good faith, reports possible unethical or illegal conduct and is in itself a serious violation of the Code of Conduct. UCHC encourages the good faith reporting of violations of the Code of Conduct and any other potential wrongdoing by UCHC, its personnel and affiliates, without fear of retaliation.

A whistleblower is any personnel who disclose information concerning acts of wrongdoing, misconduct, malfeasance, or other inappropriate behavior by any personnel, concerning the health system's investments, travel, acquisition of real or personal property, the disposition of real or person property and the procurement of goods and services. Personnel who discover wrongdoing in the health system have several options in reporting: report to his or her supervisor, to the health system's Compliance Officer, to the toll free Compliance Help Line ~ the identity of the whistleblower and the content of their report will be kept confidential consistent with the need to investigate the matter.

UCHC will not fire, discharge, demote, suspend, threaten, intimidate, harass or discriminate against personnel because of their role as a whistleblower insofar as the actions taken by the personnel are legal. Any attempt to retaliate against personnel for reporting a violation of this policy will itself be considered a violation of this policy that may result in disciplinary action up to and including termination of employment or other affiliation with UCHC. UCHC will thoroughly investigate any allegation of retaliation against a whistleblower for reporting an alleged violation of the Code of Conduct and any other potential wrongdoing.

D. COMPLIANCE PROCEDURES

The following compliance personnel and procedures are available to all health center employees.

1. **Compliance Officer**. The Compliance Officer is responsible for receiving and responding to all reports, complaints, questions about compliance issues, for tracking new developments, ensuring appropriate compliance reviews are performed, and conducting compliance training.

2. **Board Committee**. The Compliance Officer will present an annual report to a subcommittee of the Board of Trustees on the Compliance Program that includes: i) the Compliance Program's goals, objectives and work plan; (ii) an assessment of risk areas and how resources should be allocated to address such risks; and (iii) a review of how goals and objectives were or were not met for the prior year.

3. **Compliance Committee**. A Committee comprised of the Compliance Officer, members of the Board, senior management and certain department heads will meet at least on an annual basis to review the implementation and progress of the Compliance Program. As necessary, the Committee will meet more frequently to address any specific Compliance-related concerns or issues that may arise.

4. **Reporting and Complaint Procedures**. All personnel can and should raise any question they might have about potentially unethical or illegal conduct with the Compliance Officer.

5. **Confidentiality and the Compliance Helpline**. Your report or question may be raised anonymously, if you choose, and will be held in the strictest confidence possible, consistent with the need to investigate any allegations of wrongdoing. Personnel who do not wish to contact the Compliance Officer directly, may instead raise an issue or report a compliance concern by calling the dedicated voice mail "Compliance Helpline."

6. **Inquiry by the Compliance Officer**. Upon receiving a report of possible unethical or illegal conduct, the Compliance Officer will conduct an inquiry, as appropriate, in consultation with outside counsel, if necessary.

7. **Corrective Action And Discipline.**
   a) **Corrective Action**. Violations of the Code of Conduct may warrant corrective action, including, but not limited to:
   i. refunding overpayments;
   ii. additional training for personnel;
   iii. personnel being disciplined, including discharged;
   iv. suspension of billing for a particular provider or a particular of service;
   v. modification or improvement of the health center's business practices; and
   vi. modification or improvement of the Compliance Program itself to better ensure continuing compliance with applicable federal and state laws and regulations.

8. **Discipline**. All personnel are expected to adhere to this Code of Conduct and compliance standards. If the Compliance Officer concludes, after an appropriate investigation, that these standards have been violated, then appropriate discipline (including, as appropriate, a warning, suspension and/or discharge) may be imposed. The imposition of discipline can be based on the personnel's:
   a) unlawful or unethical actions,
   b) condoning or failing to report unlawful actions by others,
   c) retaliation against those who report suspected wrongdoing, or

d) other violation of the Code of Conduct and Compliance Standards.

9. **Compliance Assurance Monitoring.** The Compliance Officer will be responsible for continued monitoring of compliance with this Manual and all applicable federal and state rules, laws, and regulations.

10. **Tracking New Developments**. On a continuing basis, the Compliance Officer will keep abreast of, and review, all new regulatory or legal requirements issued by the federal or state government, including, but not limited to
    a) the monthly Medicare Information Resource;
    b) Department of Health Medicaid Updates;
    c) all new rules governing the documentation, coding and billing of serviced provided by the health center;
    d) annual updates to the Current Procedural Terminology (CPT); and
    e) New Fraud Alerts issued by the Office of Inspector General

Based on any relevant new developments, the Compliance Officer will review existing policies and procedures to ensure that the health center is in compliance with federal and state requirements.

11. **Ongoing Compliance Reviews**. On a regular basis, the Compliance Officer will cause audits to be conducted, which may include, but will not be limited to, ensuring that:
    a) the documentation and coding for both in-patient and out-patient services being billed by the health center are accurate and complete, including the documentation and coding of physician services, out-patient testing or procedures, clinic services, or other health center services;
    b) computer systems do not automatically insert information that is not supported by the documentation;
    c) if patterns of claims denials exist, they are detected; evaluated to determine the cause and appropriately corrected;
    d) third-party audits are reviewed to determine if those results reflect any systemic deficiency or problem in the health center's compliance with state or federal rules, regulations, or laws;
    e) credit balances are tracked and refunded to appropriate payors;
    f) personnel conform to appropriate policies concerning marketing and the giving or receiving of gifts and business entertainment;
    g) the health center's competitive bidding policies are appropriately followed;
    h) the health center's business practices are in compliance with applicable laws, rules and regulations. Such audits might include a review of the health center's credit balance, its practice of waiving co-payments or providing professional courtesy, and the fair market value of leases, equipment rental agreements, or personal service contracts with other providers.

12. **Exclusion Reviews**. On an monthly basis, the Compliance Officer or a designee will review the OIG's and GSA's exclusion databases to ensure that the health center does not employ or contract with anyone who has been excluded from participating in federal

healthcare programs. These databases will also be reviewed upon hiring of new personnel/contracting with new individuals or entities.

13. **Training.** The Compliance Officer will ensure that all personnel receive compliance and ethics training.

14. **Compliance Manual**. The Compliance Officer/designee is responsible for ensuring that the Compliance Manual is distributed to all personnel. All newly hired personnel should also receive a copy of this Manual and submit a signed acknowledgment form to the Compliance Officer/designee.

15. **Annual Training**. The Compliance Officer is responsible for ensuring that an annual review occurs for all staff regarding this Compliance Manual and the requirements of the Compliance Program. In addition, the Compliance Officer will develop a schedule of occasional training on compliance issues, as necessary, for new and existing personnel. The Compliance Officer/designee will maintain a record of all personnel who have attended such training.

16. **Remedial Training.** Finally, the Compliance Officer will be responsible for any remedial training that is required as part of the Compliance Program.

17. **Compliance contacts and numbers.** Health center personnel may contact the Compliance Office with any compliance question or issue. The people and telephone numbers to call are:
    a) The Compliance Officer - (718) 960-3389.
    b) Compliance Hotline - (718) 960-3705.
    c) Compliance Fax Number - (718) 960-6615.

Corporate Compliance Plan Submitted by:

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Cassandra Andrews Jackson
Compliance Officer

APPENDIX A

UCHC Health System

CODE OF CONDUCT

Table of Contents

I. POLICY STATEMENT
- A. Applicability
- B. UCHC's Mission
- C. Compliance Goals

II. CODE OF CONDUCT

APPENDIX

III. APPLICABLE LAWS
- A. Human Resource and Labor Law Compliance
- B. Family Medical Leave
- C. Americans with Disabilities Act
- D. Environmental Compliance

IV. MAINTENANCE OF CORPORATE RECORDS

V. DATA PRIVACY - SAFEGUARDING THE PRIVACY OF THE PEOPLE WE SERVE
- A. Confidentiality of UCHC' information
- B. Disclosure of Protected Health Information
- C. Government Investigations
- D. Information Owned by Others
- E. Records Retention/Destruction

VI. BEHAVIOR DEEMED UNPROFESSIONAL CONDUCT

VII. PROTECTION FOR WHISTLEBLOWERS AND PROTECTION AGAINST RETALIATION

VIII. CONFLICTS OF INTEREST

IX. DEFINITIONS

Acknowledgment of Receipt

I. POLICY STATEMENT

UCHC Health System ("UCHC") has instituted a Compliance Program[27] ("Program") to establish standards and procedures to: 1) prevent and detect criminal conduct, fraud, waste and abuse;[28] 2) to foster an environment that encourages ethical behavior and adherence to the law and ethical business practices; and, 3) to create a system of checks and balances designed "to prevent inaccurate billing and inappropriate practices in the Medicaid [and Medicare] program[s]."[29]

UCHC is committed to providing patients with high quality and caring medical services, and to providing those services pursuant to the highest ethical, business, and legal standards. These high standards must apply to our interactions with everyone with whom we deal. This includes our patients, other health care providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety. In short, we do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with UCHC. We expect and require all personnel to be law-abiding, honest, trustworthy, and fair in all of their business dealings.

UCHC has adopted, as part of the Compliance Program, a Code of Conduct which outlines standards of conduct for personnel in the workplace and in any activity where personnel's actions reflect on UCHC. Every member of personnel, volunteer, contracted practitioner or other agent of UCHC shall be familiar with its contents and adhere to its code and standards. While a person's duties will vary depending upon his or her position within UCHC, all individuals associated with UCHC are held to the same legal and ethical standards discussed herein. It is the responsibility of all persons associated with UCHC to understand, implement and uphold the standards set out in the Code of Conduct.

The Code of Conduct provides guidance to ensure that all of our work is done in an ethical and legal manner. Adherence to its spirit, as well as its specific provisions, is absolutely critical to our future. Personnel are advised to raise compliance issues or concerns with your supervisor, or you may contact the Compliance Officer at any time at (718) 960-3389, at the dedicated anonymous Compliance Hotline at (718) 960-3705, in person or in writing.

It is a basic principle of our Compliance Program that there will be no retribution for asking questions, raising concerns about the Code, or reporting possibly improper conduct. All reports to the Compliance Officer will be held in the strictest confidence possible, consistent with the need to investigate the matter.

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[27] Department of Health and Human Services Office of Inspector General; Publication of the OIG Compliance Program Guidance for health systems published in the Federal Register / Vol. 63, No. 35 / Monday, February 23, 1998 / Notices

[28] Federal Sentencing Guidelines section 8B2.1 (a)(1)

[29] Office of the Medicaid Inspector General, Mandatory Compliance Programs, Frequently Asked Questions: What is the Purpose and intent of the Mandatory Compliance Law?

A. Applicability

Unless otherwise specifically stated herein, this policy and procedure applies to all UCHC personnel.

B. UCHC's Mission

UCHC is committed to improving the health of our community and is dedicated to providing compassionate, comprehensive and innovative health care in a safe environment where the patient always comes first. All individuals will be provided complete, open and timely access to the highest quality of care, regardless of their ability to pay.

UCHC is committed to providing residents with high quality and caring medical services, and to providing those services pursuant to the highest ethical, business, and legal standards. These high standards must apply to our interactions with everyone with whom we deal. This includes our residents, other health care providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all personnel must act in compliance with all applicable federal and state standards, and strive to avoid even the appearance of impropriety.

C. UCHC's Compliance Goals

1. To prevent, detect, and correct fraud, waste, and abuse in the health system.

2. To conduct business operations and deliver healthcare services in compliance with all applicable laws, and UCHC' standards of integrity and ethical business practices.

3. To protect its reputation and standing in the patient, business, government, and regulatory community.

4. To provide a work environment that is safe, secure, professional, respectful, and free of discrimination, harassment, intimidation, and retaliation.

5. To provide medical services and deliver patient care with quality, care, dignity, integrity, and respect while observing patient rights.

6. To avoid any deceptive business practice and to comply with any applicable competition law.

7. To avoid engaging in activities that creates any conflicts of interests or the appearance thereof.

8. To maintain and operate all health system facilities in a safe manner.

9. To be committed to environmental responsibility.

10. To maintain UCHC records in accordance with applicable law, internal policies and procedures, and best practices for record management.

11. To conduct business in a fiscally responsible manner.

12. To prohibit, address, and mitigate any behavior, action, or practice that is deemed unprofessional conduct.

II. CODE OF CONDUCT

A. All health system activities must be conducted in accordance with UCHC's mission, vision and goals.

B. All health system activities must be conducted in a manner that adheres to all applicable laws rules and regulations, including, without limitation, the organization enabling statute, Center for Medicaid and Medicare (CMS) regulations; HIPAA; SAMHSA, DEA and certified opioid treatment regulations; Public Health Law; Education Law; Mental Hygiene Law; Social Services Law; Public Authorities and Accountability Act; and General Business Law.

C. Each supervisor or manager is responsible for ensuring that the personnel within his or her supervision are acting ethically and in compliance with the Code of Conduct.

D. Supervisors or managers will be sanctioned for failure to instruct adequately their subordinates or for failing to detect noncompliance with applicable policies and legal requirements, where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any problems or violations and given the health center the opportunity to correct them earlier.[30]

E. Personnel shall be completely honest in all dealings with government agencies. No misrepresentations shall be made, and no false bills or requests for payment or other documents shall be submitted to government agencies or representatives. Personnel certifying the correctness of records submitted to government agencies, including bills or requests for payment, shall have actual knowledge that the information is accurate and complete before giving such certification

F. Actions that are dishonest, unethical or in violation of the organization's policies or procedures are violations of the Code of Conduct and are strictly prohibited.

G. Personnel shall not engage in any financial, business, or other activity which competes with the health system's business which may interfere or appear to interfere with the performance of their duties or that involve the use of the health system's

[30] See HHG/OIG, Compliance Program Guidance for health systems, Notice, 63 FR 8987, 8989-8990, Feb. 23, 1998

property, facilities, or resources, except to the extent permitted under the health system's conflict of interest policies.

H. UCHC shall not engage in unfair competition or deceptive trade practices.

I. UCHC personnel are responsible for ensuring that the work environment is free of discrimination or harassment due to race, color, religion, creed, sex, national origin, citizenship status, age, disability, ethnic predisposition or carrier status, marital status, sexual orientation, transgender status, gender identity, pregnancy, veteran status or any other characteristic protected by applicable law.

J. All health system records must be retained, maintained, and destroyed in a manner consistent with the health system's record retention policies and applicable law.

APPENDIX

I. APPLICABLE LAWS

A. Human Resource & Labor Law Compliance

1. Compliance with Sexual Harassment Laws

   Any Employee who experiences sexual harassment may file a grievance with either his or her supervisor or the Human Resources Department.

2. Compliance with Equal Opportunity/Non-Harassment Laws

   UCHC does not tolerate harassment or discrimination against individuals who fall within any protected category and will treat such incidents as a form of misconduct. Sanctions shall be enforced against individuals engaging in such behavior. We provide equal opportunity to all employees.

3. Compliance with Labor and Employment Laws

   It is UCHC policy to comply fully with all applicable labor laws and other statutes regulating the employer-employee relationship and the workplace environment. Under federal and state law, it is illegal for UCHC or any affiliates to pay to or receive any money or other thing of value from any labor organization representing UCHC personnel (excluding any amount paid in the normal course of business, e.g., union dues, political action committee).

4. Conduct Relevant Background Checks on All Representatives

   UCHC will conduct comprehensive background investigation checks on all employees, volunteers and independent contractors. Background searches will include, where appropriate, a driver's abstract, education verification of highest degree obtained, Medicare and Medicaid exclusion search, federal contracting excluded parties search, personal and professional reference verification, sexual offender database search, social security number search, credit report and/or a professional license and discipline search. In addition, UCHC will require that all employees, volunteers and independent contractors comply with all policies and procedures and undergo a criminal background check. This includes conducting checks to search out any criminal convictions and/or any pending criminal charges against applicants for employment.

B. Family and Medical Leave Act ("FMLA")

FMLA provides an entitlement of up to 12 weeks of job-protected, unpaid leave during any 12-month period to eligible, covered employees for the following reasons: 1) birth and care

of the eligible employee's child, or placement for adoption or foster care of a child with the employee; 2) care of an immediate family member (spouse, child, parent) who has a serious health condition; or 3) care of the employee's own serious health condition. It also requires that employee's group health benefits be maintained during the leave. The FMLA is administered by the Employment Standards Administration's Wage and Hour Division within the U.S. Department of Labor. [31]

C. Americans with Disabilities Act ("ADA")

The ADA prohibits discrimination on the basis of disability in employment, State and local government, public accommodations, commercial facilities, transportation, and telecommunications. To be protected by the ADA, one must have a disability or have a relationship or association with an individual with a disability.

An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such impairment. The ADA does not specifically name all of the impairments that are covered.[32]

D. Environmental Compliance

1. UCHC is committed to maintaining clean, safe and healthy healing and work environments at every facility for all patients, their visitors, employees, and contractors. It is UCHC's policy to comply with all applicable health and safety laws, rules and regulations and require the use of appropriate personal protective equipment and safety measures, and insist that all work be performed in the safest possible manner in an effort to protect patients, employees, visitors and contractors from unsafe conditions.

2. UCHC is committed to ensuring that all health center and health facilities' generated waste streams are properly handled, recycled, and disposed of in accordance all applicable environmental safety laws, rules and regulations.

[31] Family & Medical Leave Act
[32] ADA www.ADA.gov

3. It is UCHC policy to dispose of, and transport potentially infectious medical, radioactive, and hazardous waste in compliance with all federal, state, and local laws and guidelines.[33]

4. All employees must report any unsafe or potentially unsafe conditions to their supervisor.

II. MAINTENANCE OF CORPORATE RECORDS

A. According to 10 NYCRR 405.10, "All records shall document, as appropriate, at least the following:

1. evidence of a physical examination, including a health history, performed no more than thirty days prior to admission or within 24 hours after admission and a statement of the conclusion or impressions drawn;

2. admitting diagnosis;

3. results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient;

4. documentation of all complications, health center acquired infections, and unfavorable reactions to drugs and anesthesia;

5. properly executed consent forms for procedures and treatments;

6. all practitioners' diagnostic and therapeutic orders, nursing documentation and care plans, reports of treatment, medication records, radiology, and laboratory reports, vital signs and other information necessary to monitor the patient's condition;

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[33] FEDERAL:
Medical Waste Tracking Act of 1988 (Federal Register: Standards for the Tracking and Management of Medical Waste, 40 CFR Parts 22 and 259 (March 24, 1989)
29 CFR, Part 1910 Regulated Medical Waste Transport
49 CFR, Part 173 Non-Bulk Packaging of Waste
40 CFR Part 266: Storage, Treatment, Transportation, and Disposal of Mixed Wastes; Final Rule (EPA)

OSHA:
29 CFR Part 1910.1030 (OSHA Exposure to Bloodborne Pathogens Regulations)

New York State:
6 NYCRR (Environmental Conservation Law), Part 360 (Solid Waste Management Facilities and 364 (Waste Transporter Permits) Regulations
10 NYCRR Part 70 (DOH Regulations - Managing Regulated Medical Waste
TAGM SW-97-10 (Disposal of Regulated Medical Waste Sharps)

discharge summary with outcome of health centerization, disposition of case and provisions for follow-up care; and

7. final diagnosis."[34]

8. All books, reports, accounts and any other information generated in the course of business must be made in a complete and accurate manner, including electronic records. It is the responsibility of every UCHC employee and affiliate to record information completely, accurately and honestly. Records must be legible and clear enough to not need interpretation. All documentation related to individual billing must be recorded at the time of service.

9. All business and financial transactions must be reported in the regular course of business. Under no circumstances should a UCHC employee or affiliate create misleading records or disguise billing or expenses. The falsification of individual treatment, attendance or billing records is strictly prohibited.

10. Records may not be altered in any way without prior approval from the Program Director. If records are to be altered, the records must reflect the date of the alteration and must be signed by the employee that altered the record and the person that approved the alteration. No person shall ever sign the name of another person to any document. Signatures should always be accompanied by the date the signature was made and such date must include the month, date and year. Documents may never be backdated or predated.

11. In the case of direct care billing documentation, if a correction needs to be made, a UCHC employee or affiliate should make a single strike through the error and initial and date the error with the current date. The initials should correspond to a full signature at the bottom of the page.

III. DATA PRIVACY - SAFEGUARDING THE PRIVACY OF THE PEOPLE WE SERVE

A. Confidentiality of UCHC Information

UCHC's personnel shall not disclose to others any confidential information obtained during the course of employment. Confidential information includes, but is not limited to, methods, processes, techniques, computer software, equipment, service marks, copyrights, research data, clinical and pharmacological data, marketing and sales information, personnel data, individual lists, financial data, plans, and any other proprietary information in the possession of the organization which has not been published or disclosed to the public.

[34] NYCRR 405.10

The health system is responsible and accountable for the integrity and protection of business information. Documents and electronic media containing sensitive information concerning individuals and the organization Representatives should be handled carefully and must be properly secured. Particular attention must be paid to the security of data stored on the computer system. If you observe misuse of confidential information, or individuals whom you do not recognize using terminals in your area, immediately report this to your supervisor or to the Privacy Officer.

B. Disclosure of Protected Health Information

To protect individuals against misuse of information, access to individual information must be limited to the extent permitted by federal and state law and UCHC policy. Any UCHC employee and affiliate who engages in unauthorized disclosure, access, or misuse of information in violation of the privacy rights of patients may be subject to disciplinary action up to and including termination of employment or other association within the organization in addition to possible civil or criminal sanctions. Any person who becomes aware of such unauthorized disclosure, access or misuse should report it immediately to their supervisor or the Privacy Officer.

1. Physician Patient Privilege

UCHC is committed to respecting patient and employee confidentiality at its highest ethical standards and to complying with applicable laws and regulations.

2. Physician - Patient Privacy

"Certain communications are vested by law with a privilege against disclosure. New York, by statute, recognizes a privilege for confidential communications between attorney and client (CPLR 4503); physician and patient (CPLR 4504); spouses (CPLR 4502); registered psychologist and client (CPLR placed "on the same basis" as attorney client privilege, CPLR4507); a certified social worker and client (CPLR 4508) and rape crisis counselor and client (CPLR 4510)."[35]

C. Government Investigations

1. All UCHC employee and affiliates must follow the appropriate procedure to ensure that the organization responds in a proper manner to all government investigations.

2. Some agencies are entitled by statute to immediate access to information. They include but are not limited to the Office of the Inspector General of the United States Department of Health and Human Services, the New York State Medicaid Fraud Control Unit, the New York State Department of Health, and the New York State Medicaid Inspector General. Proper identification must be

[35]Prince, Richardson on Evidence Article V. A General Considerations § 5-101, p. 225.

presented by officials of these agencies before access can be provided. In virtually all cases, when a request by personnel of these agencies is made, access to the requested information should be delayed pending notification of the Executive Director and/or health system's Compliance Officer. Such notification should occur simultaneously with the requested access. Notification will ensure that the organization is aware of the inquiry, properly responds to it, and can take whatever action is necessary with regard to it.

3. UCHC personnel and affiliates should be certain that any disclosure of individual or employee health information complies with all specific federal and state confidentiality laws relating to medical records, psychiatric records, AIDS and substance abuse (controlled drugs and alcohol).

D. Information Owned by Others

1. Confidential information (e.g. software, data, and reports) received from outside business associates for the benefit of UCHC must not be disclosed unless a business associate agreement has been signed. If the business associate has information in their possession that could possibly be confidential to a third party or may have restrictions placed on its use, they should consult with the Director of Information Systems.

2. "Software" is intellectual property which is protected by copyright laws and may also be protected by patent trade secret laws or as confidential information. Approval in writing must be secured from the Director of Information Systems before software can be accepted or license agreements signed for its use. The terms and conditions of such license agreements, such as provisions not to copy or distribute software, must be strictly followed. If you acquire software for your personally owned equipment, you should not copy any part of such software in any work you do for the organization, place such software on any Organization-owned computer system, or generally bring such software onto the premises.

E. Records Retention/Destruction

UCHC personnel and affiliates are expected to comply fully with the records retention and destruction policy for the department in which they work. If UCHC personnel and affiliates believe that documents should be saved beyond the applicable retention period, their supervisor should be consulted. There are criminal penalties for any person who knowingly alters, destroys, mutilates, or conceals a document with the intent to obstruct justice or influence an official investigation or proceeding.

IV. BEHAVIOR DEEMED UNPROFESSIONAL CONDUCT

A. The following actions are considered unprofessional conduct and a violation of this Code of Conduct:

1. Submitting or causing to be submitted false claims for unfurnished medical care, services or supplies[36]; an amount in excess of established rates or fees[37]; medical care, services or supplies provided at a frequency or in an amount not medically necessary[38]; amounts substantially in excess of the customary charges or costs.[39]

2. Inducing other employees to submit a false claim.[40]

3. Making any false statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the appropriate payment.[41]

4. Inducing other employees to make any false, fictitious or fraudulent statement or misrepresentation of a material fact.[42]

5. Failure to disclose any event affecting the right to payment.[43]

6. Converting any part of a medical assistance payment to use or benefit for anything other than the intended benefit by the medical assistance program.[44]

7. Soliciting or receiving either directly or indirectly any payment, including any kickback, bribe, referral fee, rebate or discount, whether in cash or in kind, in return for referring a patient to a person for any medical care, services or supplies for which payment is claimed under the program.[45]

8. Soliciting or receiving either directly or indirectly any payment, including any kickback, bribe, referral fee, rebate or discount, whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program.[46]

[36] 18 NYCRR 515.2(b)(1)(i)(a).
[37] 18 NYCRR 515.2(b)(1)(i)(b).
[38] 18 NYCRR 515.2(b)(1)(i)(c).
[39] 18 NYCRR 515.2(b)(1)(i)(d).
[40] 18 NYCRR 515.2(b)(1)(ii).
[41] 18 NYCRR 515.2(b)(2)(i).
[42] 18 NYCRR 515.2(b)(2)(ii)
[43] 18 NYCRR 515.2(b)(3)
[44] 18 NYCRR 515.2(b)(4)
[45] 18 NYCRR 515.2(b)(5)(i)
[46] 18 NYCRR 515.2(b)(5)(ii)

9. Offering or paying either directly or indirectly any payment, including any kickback, bribe, referral fee, rebate or discount, whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program.[47]

10. Offering or paying either directly or indirectly any payment, including any kickback, bribe, referral fee, rebate or discount, whether in cash or in kind, in return for referring a patient to a person for any medical care, services or supplies for which payment is claimed under the program; or in the connection with the performance of professional activities.[48]

11. Failing to maintain or to make available for purposes of audit or investigation records necessary to fully disclose the medical necessity for the nature and the extent of medical care, services and supplies furnished.[49]

12. Submitting claims or accepting payment for medical care, services or supplies furnished by a person suspended, disqualified or otherwise terminated from participation in the program.[50]

13. Seeking or accepting any gift, money, donation or other consideration in addition to the amount paid or payable under the program for any medical care, services or supplies for which a claim is made.[51]

14. Deceiving, misleading or threatening a patient, or charging or agreeing to charge or collect any fee in excess of the maximum fee, rate, or schedule amount from a patient.[52]

15. Making any agreement, combination, or conspiracy to defraud the program by obtaining, aiding or engaging anyone to obtain payment for any false claim.[53]

16. Furnishing or ordering medical care, services or supplies that is substantially in excess of the client's needs.[54]

17. Furnishing or ordering medical care, services or supplies that fail to meet professionally recognized standards for health care or which are beyond the scope of the person's professional qualifications or licensure.[55]

[47] 18 NYCRR 515.2(b)(5)(iii)
[48] 18 NYCRR 515.2(b)(5)(iv); 8 NYCRR 29.1 (b)(3)
[49] 18 NYCRR 515.2(b)(6)
[50] 18 NYCRR 515.2(b)(7)
[51] 18 NYCRR 515.2(b)(8)
[52] 18 NYCRR 515.2(b)(5)(9)
[53] 18 NYCRR 515.2(b)(10)
[54] 18 NYCRR 515.2(b)(11)
[55] 18 NYCRR 515.2(b)(12)

18. Illegally discriminating in the furnishing of medical care, services or supplies based on the patient's race, color, national origin, religion, sex, age or handicapping condition.[56]

19. Assigning payments under the program to a factor, either directly or by power of attorney; or receiving payment through any person whose compensation is not related to the cost of processing the claim, is related to the amount collected or is dependent upon collection of the payment.[57]

20. Offering or providing any premium or inducement to a patient in return for the patient's patronage of the provider or other person to receive care, services or supplies.[58]

21. Denying services to a recipient based in whole or in part upon the recipient's inability to pay a co-payment for medical care, services or supplies.[59]

22. Improper disclosure of confidential patient information.[60]

23. Any violation of the organization's policies concerning patient care or advance directives.[61]

24. Willfully or grossly negligent failure to comply with substantial provisions of Federal, State or local laws, rules or regulations governing the practice of the profession.[62]

25. Exercising undue influence on the patient or client, including the promotion of the sale of services, goods, appliances or drugs in such manner as to exploit the patient or client for the financial gain of the practitioner or of a third party.[63]

26. Permitting any person to share in the fees for professional services, other than: a partner, employee, and associate in a professional firm or health center, professional subcontractor or consultant authorized to practice the same profession, or a legally authorized trainee practicing under the supervision of a licensed practitioner.[64]

[56] 18 NYCRR 515.2(b)(13)
[57] 18 NYCRR 515.2(b)(14)
[58] 18 NYCRR 515.2(b)(15)
[59] 18 NYCRR 515.2(b)(16(iii)
[60] 8 NYCRR 29.1(b)(8)
[61] 8 NYCRR 29.1(b)
[62] 8 NYCRR 29.1(b)(1)
[63] 8 NYCRR 29.1(b)(2)
[64] 8 NYCRR 29.1(b)(4)

27. Conduct in the practice of a profession which evidences moral unfitness to practice the profession.[65]

28. Willfully making or filing a false report or failing to file a report required by law or by the Education Department or impeding or obstructing such filing, or inducing another person to do so.[66]

29. Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform, or performing without adequate supervision professional services which the licensee is authorized to perform only under the supervision of a licensed professional, except in an emergency situation where a person's life or health is in danger.[67]

30. Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience or by licensure, to perform them.[68]

V. PROTECTION FOR WHISTLEBLOWERS AND PROTECTION AGAINST RETALIATION

A. UCHC encourages the good faith reporting of violations of the Code of Conduct and any other potential wrongdoing by UCHC, its personnel and affiliates, without fear of retaliation.

B. A whistleblower is any personnel who disclose information concerning acts of wrongdoing, misconduct, malfeasance, or other inappropriate behavior by any personnel, concerning the health system's investments, travel, acquisition of real or personal property, the disposition of real or person property and the procurement of goods and services.

C. Personnel who discover wrongdoing in the health system have several options in reporting:

1. Report the matter to his or her supervisor
2. Report the matter to the health system's Compliance Officer
3. Report the matter to the toll free Compliance Help Line ~ the identity of the whistleblower and the content of their report will be kept confidential consistent with the need to investigate the matter.

[65] 8 NYCRR 29.1(b)(5)
[66] 8 NYCRR 29.1(b)(6)
[67] 8 NYCRR 29.1(b)(9)
[68] 8 NYCRR 29.1(b)(10)

D. UCHC will not fire, discharge, demote, suspend, threaten, intimidate, harass or discriminate against personnel because of their role as a whistleblower insofar as the actions taken by the personnel are legal.

E. Any attempt to retaliate against personnel for reporting a violation of this policy will itself be considered a violation of this policy that may result in disciplinary action up to and including termination of employment or other affiliation with UCHC.

F. UCHC will thoroughly investigate any allegation of retaliation against a whistleblower for reporting an alleged violation of the Code of Conduct and any other potential wrongdoing.

VI. CONFLICTS OF INTEREST

UCHC' Code of Conduct policy shall apply to all personnel, including but not limited to officers, affiliates, auxilians, and volunteers of the organization. These policies shall serve as a guide for official conduct and are intended to enhance the ethical and professional performance of the organization's directors and employees and to preserve public confidence in the organization mission.

A. UCHC personnel and affiliates shall perform their duties with transparency, without favor, and refrain from engaging in outside matters of financial or personal interest, including other employment, that could impair independence of judgment, or prevent the proper exercise of one's official duties.

B. UCHC personnel and affiliates shall not directly or indirectly, make, advise, or assist any person to make any financial investment based upon information available through the director's or employee's official position that could create any conflict between their public duties and interests and their private interests.

C. UCHC personnel and affiliates shall not accept or receive any gift or gratuities where the circumstances would permit the inference that: (a) the gift is intended to influence the individual in the performance of official business or (b) the gift constitutes a tip, reward, or sign of appreciation for any official act by the individual. This prohibition extends to any form of financial payments, services, loans, travel reimbursement, entertainment, health centerity, thing or promise from any entity doing business with or before the organization.

D. UCHC personnel and affiliates shall not use or attempt to use their official position with the organization to secure unwarranted privileges for themselves, members of their family or others, including employment with the organization or contracts for materials or services with the organization.

E. UCHC personnel and affiliates must conduct themselves at all times in a manner that avoids any appearance that they can be improperly or unduly influenced, that they

could be affected by the position of or relationship with any other party, or that they are acting in violation of their public trust.

F. UCHC personnel and affiliates may not engage in any official transaction with an outside entity in which they have a direct or indirect financial interest that may reasonably conflict with the proper discharge of their official duties.

G. UCHC personnel and affiliates shall manage all matters within the scope of the organization's mission independent of any other affiliations or employment. Directors, including ex officio and board members, shall strive to fulfill their professional responsibility to the organization without bias and shall support the organization's mission to the fullest.

H. UCHC personnel and affiliates shall not use authority, property, including equipment, telephones, vehicles, computers, or other resources, or disclose information acquired in the course of their official duties in a manner inconsistent with federal, state or local law or policy and the organization's mission and goals.

I. This Code of Conduct shall be provided to all personnel upon commencement of employment or appointment and shall be reviewed annually by the Governance Committee.

J. Penalties

In addition to any penalty contained in any other provision of law, the organization director or employee who knowingly and intentionally violates any of the provisions of this code may be removed in the manner provided for by law, rules or regulations.

K.Reporting Unethical Behavior

UCHC personnel and affiliates are required to report possible unethical behavior by any personnel, including directors or officers of the organization. Personnel and affiliates may file ethics complaints anonymously and are protected from intimidation and retaliation by UCHC policies.

VII. DEFINITIONS

Abuse: Practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs to the medical assistance program, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care.[69]

[69] 18 NYCRR 515.1(1)

Center for Medicaid and Medicare ("CMS"): The Health and Human Services agency responsible for Medicare and parts of Medicaid.[70]

Claim: A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through fiscal intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier.[71]

Contaminated: The presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.[72]

Drug Enforcement Administration ("DEA"): The federal law enforcement agency responsible for enforcing the controlled substances laws and regulations of the United States.[73]

Fraud: An intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person and includes the acts prohibited by section 366-b of the Social Services Law.[74]

Furnish: Medical care, services or supplies provided directly by, or under the supervision of, or ordered or prescribed by the person.[75]

Good Faith: Information concerning potential wrongdoing is disclosed in "good faith" when the individual making the disclosure reasonably believes such information to be true and reasonably believes that it constitutes potential wrongdoing.[76]

Health Insurance Portability and Accountability Act ("HIPAA"): A federal regulation to guarantee patients' rights and protections against the misuse or disclosure of their health records.[77]

Medical Waste: Any solid waste that is generated in the diagnosis, treatment, or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biologicals. This definition includes, but is not limited to: blood-soaked bandages; culture dishes and other glassware; discarded surgical gloves; discarded surgical instruments; discarded needles used to give shunts or draw blood (e.g., medical sharps); cultures, stocks, swabs used to inoculate cultures; removed body organs (e.g., tonsils, appendixes, limbs); or discarded lancets[78]

[70] See http://www.cms.gov/apps/glossary/default.asp?Letter=C&Language=English
[71] Id., 18 NYCRR 515.1(3)
[72] OSHA
[73] See http://www.justice.gov/dea/agency/mission.htm
[74] 18 NYCRR 515.(7)
[75] Id. at (8)
[76] See ABO Recommended Guidance, Whistleblower Access and Assistance Program, pg. 2
[77] See http://www.cms.gov/apps/glossary/default.asp?Letter=H&Language=English
[78] Medical Waste Tracking Act of 1988

Substance Abuse and Mental Health Services Administration ("SAMHSA"): The Health and Human Services agency established to target effectively substance abuse and mental health services to the people most in need and to translate research in these areas more effectively and more rapidly into the general health care system.[79]

Wrongdoing is defined as fraudulent, criminal, unethical, wasteful or abusive behavior. Any alleged corruption, fraud, criminal or unethical activity, misconduct, waste, conflict of interest, intentional reporting of false or misleading information, or abuse of authority engaged in by a UCHC employee that relates to the health system.[80]

Whistleblower: UCHC personnel who in good faith discloses information concerning wrongdoing by UCHC personnel, or concerning the business of the health system itself.[81]

Regulated Medical Waste: Consists of a variety of materials, including infectious animal wastes, human pathological waste, human blood and blood products, needles and syringes (sharps) and cultures and stocks (microbiological materials) generated in research or health care.[82]

Regulated Waste: liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials that are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials[83]

[79] See http://www.samhsa.gov/about/
[80] Id.
[81] See ABO Recommended Guidance, Whistleblower Access and Assistance Program, pg. 2
[82] New York State Department of Environmental Conservation
[83] (OSHA)

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Compliance Manual for UCHC health center Health System's Compliance Program.

I agree to read the Manual, to conduct myself in conformity with all of its requirements, to adhere to the spirit and letter of the Code of Conduct, and to cooperate with management in carrying out the objectives of the Compliance Program.

Acknowledged and agreed:

_____
Signature

_____
Print name

_____
Job Title or Description

_____, 20__
Today's Date

APPENDIX B

CY 2014 System Wide Risk-Assessment

Table of contents

INTRODUCTION …….

PART I

Why is it necessary to have a process for identifying/assessing risk?

A. Internal requirements

B. External requirements (Regulatory mandates and agency guidance)

PART II

How UCHC identifies and assesses risk

A. Defining Risk

B. Identifying Risk

1. Various Approaches Are Available to Identify Risk
2. The "Self-Identified Risk Assessment Exercise"

C. Assessing and Prioritizing Risk
1. Overview
2. Risk Assessment Scoring
3. Prioritizing the risks

D. Development of the FY2015-2016 Compliance Work Plan

INTRODUCTION

This CY 2014 System-wide risk Assessment (the "Risk Assessment") outlines the process that Union Community Health Center ("UCHC") will utilize in creating the calendar year 2015-2016 ("CY 2015-2016") UCHC Compliance Work Plan. That process will begin on or about October 23, 2014 and should be completed by January 15, 2015.

The Risk Assessment is undertaken in furtherance of New York State Social Services Law §363-D(2)(F) and Regulation 18 N.Y.C.R.R. §521.3(c)(6), which require the establishment of "a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of [Medicaid] beneficiaries."[84]

The Risk Assessment is a component of UCHC's Compliance Program (hereinafter referred to as the "Program"). The Compliance Officer is responsible for implementing, overseeing, and monitoring the Program which is centered on promoting the prevention, detection and correction of fraud, waste, and abuse, as well as any other unprofessional or criminal conduct; and ensuring UCHC's compliance with City, State and Federal laws, rules, and regulations, and its own business and ethical standards of practice.

The Risk Assessment is comprised of two parts:

- Part I discusses the necessity of a Risk Assessment process.

[84] 18 NYCRR § 521.3(c)(6)

- Part II discusses sources that UCHC reviewed to establish the Risk Assessment, and the process that UCHC will use to identify and assess risk areas to create the FY2015-2016 Work Plan. This includes a review of pre-defined lists of risk areas identified by, among other authorities, the U.S. Department of Health and Human Services ("HHS") Office of the Inspector General ("OIG"), the New York State Department of Health ("DOH") Office of the Medicaid Inspector General ("OMIG"), as well as reviews of external and internal audits. It will also include a survey tool to be used by key UCHC personnel who will assist in identifying risk. Finally, it describes the process that UCHC will follow to assess and prioritize those risks.

PART I

Why is it necessary to have a process for identifying/assessing risk?

A. Internal Requirements

As outlined in 18 NYCRR section 521.3-Compliance Program required Provider Duties, St. Barnabas is required to have a compliance program which has "a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluation and audits, credentialing, and quality of care of medical assistance program beneficiaries."[85] UCHC has a compliance program which describes internal requirements for the performance of a risk assessment found under UCHC's Compliance Plan (091613) which provides that:

[85] 18 NYCRR Part 521

"In summary, St. Barnabas will determine which processes are at high risk for non-compliance and then prioritize these high risk processes into an annual work plan. In an effort to focus resources and activities, the Compliance Program will utilize previously released annual work plans by the Office of Inspector General (OIG) and the Office of the Medicaid Inspector General (OMIG) to identify areas to be assed for risk. The risk assessment is carried out through staff interviews, discussion with Senior Administration and documentation reviews such as minutes, enforcement actions, Fraud alerts etc."[86]

B. External Requirements (Regulatory Mandates and Agency Guidance)

A number of external sources require that organizations such as UCHC perform a self-identification and assessment of risks. Below is an overview of State requirements and federal agency guidance, focusing on compliance program risk assessment and the appropriate scope thereof:

New York Law

The New York Social Services Law requires that providers implement a mandatory compliance program 'that reflect[s] [the] provider's size, complexity, resources, and culture"[87] One of the required elements of such a program is a "system" for routine identification of compliance risk areas specific to the provider type…"[88]

In its guidance to general health centers, OMIG also: (1) recommends written policies and procedures to delineate processes to routinely identify compliance risk areas specific to the health center; and (2) periodic assessments to identify the health center's risk areas, and, as applicable, consideration of, among other things: Work Plans and publications issued by OMIG; Work Plans issued by the HHS OIG; OMIG audits; DOH survey and surveys by any other appropriate New York State or Federal agency; risk areas by any appropriate New York State

18 NYCRR Part 521
ital Compliance Plan, September 16, 2013 p.9
[87] N.Y. Soc. Serv. Law §363-d(1)
[88] N.Y. Soc. Serv. Law §363-d(2); N.Y.C.R.R. §521.3(c) (6)

agencies; risk areas identified in guidance issued by the OIG; surveys by accrediting bodies; and changes to applicable laws and regulations.[89]

United States Sentencing Commission Federal Sentencing Guidelines

Under the Federal Sentencing Guidelines ("FSG"), which OMIG also suggests providers consult, organizations such as UCHC are expected to "periodically assess the risk of criminal conduct . . . ."[90] The FSG observes in commentary that an organization should assess: (i) the likelihood of criminal conduct occurring; (ii) the nature and seriousness of such conduct if it does occur; and, (iii) the prior history of the organization.[91]

HHS OIG Guidance

The OIG, in its compliance guidance, "strongly encourages health centers to identify and focus their compliance efforts on those areas of potential concern or risk that are most relevant to their individual organizations."[92] health centers should develop "detailed annual audit plans designed to minimize the risk associated with improper claims and billing practices."[93]

In practical terms, this means that UCHC's Program must periodically assess which UCHC activities and processes are at risk for non-compliance and then categorize and prioritize those risks into an annual Work Plan designed to address each risk through a plan of correction.[94] This "ongoing evaluation process is critical to a successful compliance program."[95]

[89] See OMIG Compliance Program Guidance for health centers, Issued May 11.2012, at 28
[90] 2012 FSG §8b2.1(c)
[91] See id. at §8b2.1(c); Commentary 7(A)
[92] See OIG Supplemental Compliance Program Guidance for health centers, §I.B, 70 Fed. Reg. 4858, 4859 (2005)
[93] Id. at §III.B.5, 70 Fed. Reg. at 4875
[94] See generally 2012 FSG §8b2.1(c); see also Commentary: Application Notes 7 [discussing application of §8b2.1(c)]
[95] OIG Compliance Program Guidance for health centers, at §II.F, 63 Fed. Reg. 8987, 8996 (1998)

PART II

How UCHC Identifies and Assesses Risk

A. Defining Risk

As the first step in identifying the risks applicable to UCHC, it is necessary to understand what "risk" is. Risk has been described as "a measure of the extent to which an entity is threatened by a potential circumstance or event, and is typically a function of: (i) the adverse impacts that would arise if the circumstance or event occurs; and (ii) the likelihood of occurrence."[96] In simpler terms, "[r]isks are events or conditions that may occur and, if they do occur, would have a harmful effect"[97] on UCHC.

Risks generally fall into two distinct categories: (i) *inherent risks*, the possibility of an undesired circumstance coming to fruition without due consideration of any factors that may mitigate such a risk; and (ii) *residual risks*, which are those risks that remain even after employing corresponding internal controls.[98]

B. Identifying Risk

1. **Various Approaches Are Available for Identifying Risk:** Generally, there are three distinct approaches that may be taken to identify risk:[99]
   - **a.** Conducting a survey of key subject matter expert corporate stakeholders utilizing generic open-ended questions – developed by the Corporate Compliance Officer – to determine the presence and scope of risks;
   - **b.** Conducting one-on-one interviews or small group meetings regarding the presence of corporate risks; and

[96] NIST, U.S. Dept. of Commerce, Guide for Conducting Risk Assessments (Special Publication 800-30) Information Security, September 2012, at 6.
[97] HCCA Professional's Manual, Risk Assessment Chapter, ¶40,105, at 41,001.
[98] Id.; see also COSO, Risk Assessment in Practice, October 2012, at 7.
[99] HCCA Professional's Manual, ¶40,120, at 41,006, discussing risk identification.

c. Utilizing a list of pre-defined compliance risks developed from various internal and external sources.

The Health Care Compliance Association ("HCCA") has noted that organizations may use a combination of approaches to identify potential compliance risk.[100] Indeed, UCHC has determined that a combined approach is most appropriate for UCHC.

UCHC has a process for reviewing the pre-defined list of compliance risks (see (c) above). That list includes the following:

- the OIG and OMIG Work Plans;[101]
- Government fraud alerts and advisories, such as the OIG Special Fraud Alerts and Special Advisory Bulletins;
- Compliance Program guidance documents from the OIG and OMIG; and
- Audits of UCHC by outside agencies (e.g., Deficit Reduction Act Medicaid Integrity Contractor and Recovery Audit Contractor Audits, regulatory agency survey findings).

In addition to the above external sources, UCHC also has a process for reviewing various internal sources to identify risk. These internal sources include:

- UCHC Compliance Committee meetings.
- HIPAA/HITECH breaches, complaints, and reports.
- UCHC confidential compliance hotline reports.
- Data mining reports.
- past risk assessments

[100] Id.

[101] UCHC's proactive approach to compliance is demonstrated by the consideration of items in these Work Plans, which simultaneously provide a more focused and structured risk identification process. See generally id., ¶40,120 at 41,010.

- Internal audits.

UCHC also conducts one-on-one interviews and small group meetings on an ad-hoc basis as necessary and appropriate in identifying and assessing risk (see (b) above).

To further enhance its ability to identify and assess risk, UCHC has established a process, described below, for conducting a "Self-Identified Risk Assessment Exercise," which includes a survey of key personnel to determine the presence and scope of risk (see (a) above.

2. <u>The "Self-Identified Risk Assessment Exercise (the "Exercise" or "Survey")</u>

a. Overview: In accordance with the risk assessment responsibility and to actively engage Senior Administration who have direct oversight of day-to-day operations for various business areas and entities throughout the System, UCHC has developed a Self-identified Risk Assessment Exercise, or Survey, as an integral component of the System-wide Risk Assessment process. Each member of the Corporate Compliance Committee ("CCC") will be asked to complete this Exercise, which entails identifying their top three risks. Subsequently, through a collaborative effort involving each member of the Committee, the CCC will assign scores to each risk and prioritize those risks (as discussed in C.2 and C.3 below).

Thereafter,

- UCHC will utilize the results of the Exercise conducted by the CCC in conjunction with the internal and external sources discussed above, to develop a final draft FY2015-2016 Corporate Compliance Work Plan. The final draft is likely to include both System-wide items and facility specific items.

- Upon approval by the Board of Trustees, the System-wide Work Plan shall then be available for implementation across the System and at specific facilities.

b. Instructions for Completing the Exercise: Below are detailed guidance and instructions to be used in completing the Risk Assessment Exercise. The goal is to determine which risks put UCHC in a vulnerable position, and to determine how well controlled those risks are.[102] This guidance includes step-by-step instructions and a sample of a completed Exercise. Attached (*See* Attachment "A") is a sample Risk Assessment Grid.

The Exercise asks you to identify the "top three compliance risks," which might be described as those that "keep you up at night."[103] In selecting your top three, you should consider the following factors:

- whether the risk has a high likelihood[104] of occurrence;
- whether UCHC is highly vulnerable[105] to the risk (i.e. vulnerability increases if UCHC has insufficient internal controls in place, or if the occurrence is not easily detectable); and
- Whether the risk, if realized, would have a high adverse impact[106] on the department or area for which you are responsible. The impact could be, for example, significant legal exposure, financial liability, reputational harm, or any other types of impact that you might think of, such as operational

[102] HCCA Professional's Manual, Risk Assessment Chapter, ¶40,120, at 41,007.
[103] Id., 40,120, at 41,006 (suggesting that those being surveyed identify risks that "keep [them] up at night.")
[104] Likelihood represents the possibility that a given event will occur. COSO, *Risk Assessment in Practice,* October 2012, at 5.
[105] Vulnerability is the susceptibility of UCHC to the risk event, considering controls currently in place to prevent a risk event from occurring and its adaptability to respond to a risk event if it should occur. Vulnerability also considers whether the risk event is easily detectable. Risk events that are not easily detected increase vulnerability. HCC Professional's Manual ¶40,125, at 41,015.
[106] Impact or consequence is the extent to which a risk event might affect UCHC. COSO, *Risk Assessment in Practice, October 2012, at 3. Organization may define impact as financial, reputational, or legal,* See HCCA Professional's Manual, Risk Assessment Chapter, ¶40,125, at 41,013.

interruption or patient, public, and employee safety, to name a few.[107] (*See* Attachment "B" – Risk Assessment Scoring)

To assist you in identifying your top three risks areas, please review the list of pre-defined risk areas set forth in the UCHC Risk Assessment Tool ("Tool") which is a risk assessment scoring tool customized for UCHC. The Tool includes items previously identified by UCHC and included in the FY 2013 and FY 2014 Draft Work Plans. You should consider items from the Tool that correspond to your scope of responsibilities. Please note, however, that your top three risks items need not come from the Tool. You may include any compliance risk of which you are aware. Nonetheless, you must at the minimum thoroughly review these predefined risk areas and make a determination of whether they warrant inclusion as one, if not all, of your top three risks.

In addition to selecting your top three risk areas, please include a brief descriptive summary of each risk under the Risk Column. Define your risk in specific terms. Provide specific details on what led you to choose these three risks as your top three (e.g. lack of current controls, description of current controls and your perception of the effectiveness of those controls, financial or legal impact, any other type of impact anticipated).[108]

For example, instead of defining a risk as "Stark compliance," which would be extremely difficult to analyze, one might describe the same risk as 'health center payment to a physician without a fully executed agreement.'[109]

C. Assessing and Prioritizing Risk

[107] HCCA Professional's Manual, Risk Assessment Chapter, ¶40,120, at 41,007 and ¶40,125, at 41,013.
[108] See id., ¶40,120, at 41,007 (suggesting that those being surveyed describe impact and current controls).
[109] Id., ¶40,105, at 41,001.

1. Overview: Once all the Exercise results are received, the CCC will begin the risk assessment, which is the process by which the identified risks are evaluated and prioritized.[110]

It is important to first recognize that "risk assessments are often not precise instruments of measurement."[111] Rather, individual provider characteristics should be considered.[112] State law recognizes this guiding principle.[113]

To evaluate the Survey results, the CCC will meet and utilize the Tool, and assign consensus scores to prioritize the identified risks.[114] Where necessary, members of the CCC may conduct follow-up interviews with those surveyed or others involved with the risk area identified to clarify any information needed to complete the risk analysis.[115] The CCC will review and score the risks, so that the top priority risks are included in the UCHC bi-annual Work Plan. To evaluate the identified compliance risks, UCHC has established scoring definitions in its Risk Assessment Scoring Tool.[116]

2. Risk Assessment Scoring: UCHC has chosen to adopt the HCCA's overall approach to scoring the Survey results. The CCC will score the impact, vulnerability, and current controls associated with identified risks.[117] (*See* Attachment "B" – *Risk Assessment Exercise Scoring*) Below are the scales for each factor:

a. Impact: Impact on reputation, finances, and legal will be considered and assigned a score, as follows:

Impact on Reputation

[110] Id.
[111] NIST, Guide for Conducting Risk Assessments, at ix.
[112] HCCA Professional's Manual, Risk Assessment Chapter, ¶40,120 at 41,006.
[113] See N.Y. Soc. Serv. Law §363-d(1).
[114] See HCCA Professional's Manual, Risk Assessment Chapter, ¶40,125, at 41,018 (discussing how a small group of key stakeholders might assign consensus risk scores).
[115] See id., ¶40,120 at 41,006.
[116] Id., ¶40,125 at 41,018
[117] See Id., (HCCA's sample uses a scale of 1-5, but UCHC has chosen to simplify the scale to a 1-3 rating, utilizing the HCCA definitions for 1, 3, 5 shown in its sample. HCCA acknowledges that the scales can be customized.

Score 1 = Little or no reputation risk to/at System or facility level.

Score 2 = Moderate reputation risk. Probable bad press. Probable modest physician, patient or constituent fallout.

Score 3 = Extensive and prolonged negative press coverage. Significant sponsor/board questions of management. Extensive patient, physician, or constituent fallout.[118]

Impact on Finances

Score 1 = Loss, or additional expense is less than .05 percent of gross revenue (excluding legal fines/penalties.

Score 2 = Loss, or additional expense is between .1 percent - .5 percent of gross revenue (excluding legal fines/penalties

Score 3 = Loss, or additional expense is greater than 1 percent of gross revenue (excluding legal fines/penalties.[119]

Legal Impact

Score 1 = Technical violation of law or regulation. Little or no fine probable.

Score 2 = Civil fines or penalties up to $1 million probable. Modest risk of exclusion. CIA possible.

Score 3 = Criminal conviction or exclusion of facility or system probable plus high fines, penalties, and/or extensive legal exposure. CIA certain.[120]

b. Vulnerability: Next, the CCC will assess how vulnerable UCHC is to the risk. This will include a determination of how likely it is that the risk will occur and how detectable the risk is. The severity scale for likelihood and detectability is:

Likelihood of Risk

Score 1 = Low risk, unlikely to occur. Historical and industry experience show low likelihood of occurrence.

Score 2 = Moderate risk of occurrence within the next 12 months. Isolated to one facility.

[118] See id., ¶40,125 at 41,016-17
[119] Id.
[120] Id.

Score 3 = High risk of occurrence. Likely to occur in next 12 months. Highly complex process with numerous hand-offs. Relies on extensive specialized skills[121]

Detectability of Risk

Score 1 = Failures are likely to be detected. Process is directly supervised. Automated safeguards for identifying variations/errors.

Score 2 = Moderate risk that failure will not be detected. Limited safeguards in place to identify failure prior to occurrence. Partially automated process with limited management oversight.

Score 3 = Extremely hard to detect prior to failure. Highly automated with little or no human intervention, oversight or control. No built-in safeguards, cross-checks, or other mechanisms to identify errors/failures prior to submission/completion.[122]

c. Internal Controls: Finally, the CCC will assess whether there are controls in place already to mitigate the risk (i.e. policy controls, process controls (i.e. second level approval), automated controls, or audit controls).[123]

Current Internal Controls

Score 1 = Internal and automated controls proven to be highly effective in mitigating all risk.

Score 2 = Periodically audited and tested. Corrective action plans developed and tested for effectiveness. Limited performance metrics established. Risk management plans expected to manage the risks appropriately.

Score 3 = No formal controls in place. No risk management plans or steps in place currently.[124]

3. Prioritizing the risks: Once the scores have been assigned, the risks can be prioritized by the CCC. The score for each of the impact ratings (reputation, financial, legal) are added together to equal the *Risk Impact*. That sum is multiplied by the scores assigned to

[121] Id.
[122] Id.
[123] Id., ¶40,125, at 41, 015.
[124] Id., ¶40,125, at 41, 016-17.

likelihood and detectability to give the *Vulnerability score*. Finally, the *Risk Prioritization Score* is calculated by multiplying the Vulnerability score by a percentage associated with each internal control score, as follows:[125]

Control Score 1 (total control) = 0% of the Vulnerability score.

Control Score 2 (moderate control) = 50% of the Vulnerability score.

Control Score 3 (no control) = 100% of the Vulnerability score.

For example, if the CCC were to evaluate the risk for Advanced Beneficiary Notification based on the following scores (Impact: Reputation – 2, Financial – 2, Legal – 2; Vulnerability: Likelihood – 3, Detectability – 2; and Internal Controls – 2), the calculation would be:

2 + 2 + 2 = Risk Impact of 6;

6 x 3 x 2 = Vulnerability score of 36;

36 x .50 = Risk Prioritization Score of 18.

Similarly, if the CCC were to evaluate a risk for the 60 Day Rule AKA Reverse False Claims based on the following scores: Impact: Reputation – 3, Financial – 3, Legal – 3; Vulnerability: Likelihood – 3, Detectability – 2; and Internal Controls – 3), the calculation would be:

3 + 3 + 3 = Risk Impact of 9;

9 x 3 x 2 = Vulnerability score of 54;

54 x 1.00 = Risk Prioritization Score of 54.

[125] Id., ¶40,125, at 41, 018-19.

The Reverse False Claims (score 54) would take priority over the advanced beneficiary notification risk (score 18). In this way, the CCC will be able to prioritize the identified risks, those risks with higher risk prioritization scores would be of a higher risk.[126] (*See* Attachment "C" for a Sample Calculation of Risk Prioritization Scores).

D. Development of the CY 2015-2016 Compliance Work Plan

Through this process, those risks that fall outside UCHC's established tolerance for risk[127] will be addressed and included in the annual Work Plan, to be further evaluated and, where necessary included in mitigation plans. Once all the risks have been prioritized, as described in C. 3. above, the CCC will authorize the FY 2015-2016 Corporate Compliance Work Plan for approval and presentation to the Audit Committee of the UCHC Board of Directors.

[126] See id. (examples given on HCCA's methodology for calculating the risk prioritization score, but specific numbers assigned were changed to accommodate the customized scale of 1-3.)
[127] Id., ¶40,150, at 41, 024-25.

ATTACHMENT "A"

UCHC RISK ASSESSMENT EXERCISE		
Facility:	**Employee Name:**	**Date Completed:**
Department:	**Title:**	**Contact Phone #:**
Identify your "top three (3) compliance risks." Please include a brief descriptive summary of each risk below. Define your risk In specific terms. Provide specific details on what led you to choose these particular risks e.g. (1) lack of current controls, description of current controls, and your perception of the effectiveness of identified current controls; and (2) the financial, legal, reputational, or any other type of impact anticipated.		
Risk # 1 Untimely reporting by staff of suspected maltreatment of resident at Skilled Nursing Facility. Situation is detrimental to the subject patient's safety and wellbeing. Violation of the Elder Justice Act may result in fines and possible exclusion of participation in Federal Healthcare Programs. Negative impact to UCHC/SBRCCC reputation, as well as its financial and legal standing. No knowledge of any internal controls present.		
Risk # 2		
Risk #3		

ATTACHMENT "B"

RISK ASSESSMENT EXERCISE SCORING[1]						
	IMPACT			**VULNERABILITY**		
Score	**Reputation**	**Financial**	**Legal**	**Likelihood**	**Detectability**	**INTERNAL CONTROLS**
1	Little or no reputation risk to/at System or facility level.	Loss, or additional expense is less than .05 percent of gross revenue (excluding legal fines/penalties.	Technical violation of law or regulation. Little or no fine probable.	Low risk, unlikely to occur. Historical and industry experience show low likelihood of occurrence.	Failures are likely to be detected. Process is directly supervised. Automated safeguards for identifying variations/errors.	Internal and automated controls proven to be highly effective in mitigating all risk.
2	Moderate reputation risk. Probable bad press. Probable modest physician, patient or constituent fallout.	Loss, or additional expense is between .1 percent - .5 percent of gross revenue (excluding legal fines/penalties.	Civil fines or penalties up to $1 million probable. Modest risk of exclusion. CIA possible.	Moderate risk of occurrence within the next 12 months. Isolated to one facility.	Moderate risk that failure will not be detected. Limited safeguards in place to identify failure prior to occurrence. Partially automated process with limited management oversight.	Periodically audited and tested. Corrective action plans developed and tested for effectiveness. Limited performance metrics established. Risk management plans expected to manage the risks appropriately.
3	Extensive and prolonged negative press coverage. Significant sponsor/board questions of management. Extensive patient, physician, or constituent fallout	Loss, or additional expense is greater than 1 percent of gross revenue (excluding legal fines/penalties	Criminal conviction or exclusion of facility or system probable plus high fines, penalties, and/or extensive legal exposure. CIA certain	High risk of occurrence. Likely to occur in next 12 months. Highly complex process with numerous hand-offs. Relies on extensive specialized skills	Extremely hard to detect prior to failure. Highly automated with little or no human intervention, oversight or control. No built-in safeguards, cross-checks, or other mechanisms to identify errors/failures prior to submission/completion	No formal controls in place. No risk management plans or steps in place currently

[1] Definitions derived from HCCA Professional's Manual, Risk Assessment Chapter, ¶40,125, at 41,016-17.

Sample Calculation of Risk Prioritization Scores[129]

	IMPACT				VULNERABILITY				
Risk	Reputational	Financial	Legal	***Risk Impact***	Likelihood	Detectability	***Vulnerability Score***	Internal Control Score	**Risk Prioritization Score**
Advanced Beneficiary Notification (ABN)	2	2	2	6	3	2	36	2	18
60 Day Rule AKA Reverse False Claims	3	3	3	9	3	2	54	3	54

Reputation + Financial + Legal = **Risk Impact**

Risk Impact x Likelihood x Detectability = **Vulnerability Score**

Vulnerability Score x [% based on the assigned Internal Control Score] = **Risk Prioritization Score**

EXAMPLE:

If the Internal Control Score was 1, multiply by 0%

If the Internal Control Score was 2, multiply by .50%

If the Internal Control Score was 3, multiply by 100%

The greater the **Risk Prioritization Score**, the higher the overall risk.

In this example, the 60 Day Rule score of 54 would take priority over the ABN score of 18.

[129] Calculation methodology was derived from the HCCA Professional's Manual, Risk Assessment Chapter, ¶40,125, at 41,018-19.

ATTACHMENT C
UCHC Health System Reporting
Table of Organization