AUDIT COMMITTEE
MEETING AGENDA

December 6, 2012

3:00 P.M.

125 Worth Street,
Rm. 532
5th Floor Board Room

CALL TO ORDER — **Ms. Emily A. Youssouf**

- **Adoption of Minutes September 25th, 2012** — **Ms. Emily A. Youssouf**

INFORMATION ITEMS

- **Internal Audits Update** — **Mr. Chris Telano**
- **Compliance Update** — **Mr. Wayne McNulty**

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: September 25th, 2012
TIME: 3:00PM

COMMITTEE MEMBERS
Emily A. Youssouf, Chair
Jo Ivey Boufford, MD
Josephine Bolus, RN

OTHER MEMBERS OF THE BOARD
Michael A. Stocker, MD

STAFF ATTENDEES
Antonio Martin, Executive Vice President/CCOO
Barbara Keller, Deputy Counsel, Legal Affairs
Deborah Cates, Chief of Staff, Chairman's Office
Patricia Lockhart, Secretary to the Corporation, Chairman's Office
Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits
Wayne McNulty, Corporate Compliance Officer
James Linhart, Deputy Corporate Comptroller
Kathleen McGrath, Senior Director, Central Office
Gassenia Guilford, Senior Director, Finance, Central Office
Anthony Saul, Sr. Associate Director, Dr. Susan Smith McKinney Nursing & Rehabilitation Center
Glenford Hall, Associate Director, Dr. Susan Smith McKinney Nursing & Rehabilitation Center
David Dyer, Associate Director, Dr. Susan Smith McKinney Nursing & Rehabilitation Center
Mauvareen Beverly, Deputy Executive Director, Kings County Hospital Center
William Swensen, Deputy Chief Financial Officer, Kings County Hospital Center
Danielle Downer, Sr. HCPPA, Kings County Hospital Center
Mauvareen Beverly, Deputy Executive Director, Kings County Hospital Center
Gloria Ranghelli, Chief Financial Officer, Coler-Goldwater Specialty Hospital & Nursing Facility
Julian John, Chief Financial Officer, Central Brooklyn Family Health Network
Brian Ancona, Controller, Gouverneur Healthcare Services
Christopher Byrne, Controller, Bellevue Hospital Center
Mike Milinic, Controller, Queens Health Network
L.R. Tulloch, Deputy Chief Financial Officer, Harlem Hospital Center
Zaheer Baig, Controller, Woodhull Medical & Mental Health Center
Keisha Watkins, Assistant Controller, Bellevue Hospital Center
Kim Wilcott, Assistant Director, Coney Island Hospital
Elvira O. Rivera, Assistant Coordinating Manager, Gouverneur Healthcare Services
Devon Wilson, Senior Director, Office of Internal Audits
Roger Mayer, Director, Office of Internal Audits
Steven Van Schultz, Director, Office of Internal Audits
Chalice Diakhate, Director, Office of Internal Audits
Zhanna Kelley, Assistant. Director of Internal Audit, Office of Internal Audits
George Asadoorian, Supervising Confidential Examiner, Office of Internal Audits
Andre Deazle, Supervising Confidential Examiner, Office of Internal Audits
Cynthia McIntosh, Supervising Confidential Examiner, Office of Internal Audits
Roger Novoa, Supervising Confidential Examiner, Office of Internal Audits
Delores Rahman, Supervising Confidential Examiner, Office of Internal Audits
Frank Zanghi, Supervising Confidential Examiner, Office of Internal Audits
Sonja Aborisade, Associate Confidential Examiner, Office of Internal Audits
Jozef Dubroja, Associate Confidential Examiner, Office of Internal Audits
Satish Malla, Associate Confidential Examiner, Office of Internal Audits

OTHER ATTENDEES
PAGNY: Robert McKenna, Site Administrator

SEPTEMBER 25, 2012
AUDIT COMMITTEE OF THE BOARD OF DIRECTORS
NYC HEALTH & HOSPITALS CORPORATION

An Audit Committee meeting was held on Tuesday, September 25, 2012. The meeting was called to order at 3:00 P.M. by Ms. Emily Youssouf, Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee meeting held on September 13, 2012. A motion was made and seconded with all in favor to adopt the minutes.

Ms. Youssouf moved onto an information item which is an update from Internal Audit.

Mr. Christopher Telano saluted the committee and stated that the first audit he will discuss is the review of Payroll at Harlem related to the PAGNY (Physicians Affiliate Group of New York) affiliation. During the first nine months of 2011, PAGNY management found that some employees were being overpaid. They noted that 52 overpayments were made totaling $162,000. Internal Audit was asked to come in to ensure that procedures implemented as of October 2011 to stop the overpayments were being adhered to. Audit was also asked to review the entire payroll process for other inefficiencies. While we found an additional 23 overpayments for the nine-month period, we did not find any in the last three months of 2011. We concluded that the tighter controls they implemented were effective.

Dr. Michael Stocker, Chairman of the Board asked if there was a representative from PAGNY. Mr. Robert McKenna, Administrator for PAGNY was present and introduced himself as such. Dr. Stocker commented that they had heard complaints that physicians were overpaid and wanted to know how it happened. Mr. McKenna stated that there were a couple of situations where vacation pay was duplicated. In other words, they got paid for regular hours and vacation time as well. In certain cases, salary increases were implemented without approval. The biggest problem was in the beginning when each payroll was implemented from zero. In a lot of the cases the extra hours were entered because they were being input by different people.

Dr. Stocker asked if the system is now automated. Mr. McKenna responded that it is fully implemented on ADP. They have a dual system in Excel that runs parallel to every single payroll and is matched line for line, provider by provider. Dr. Stocker asked how they record hours worked. Mr. McKenna said that they record the hours worked in ADP based on the different categories; sick, regular, vacation, etc. Dr. Stocker asked if timesheets are submitted. Mr. McKenna responded that each employee gets a time sheet that gets entered biweekly.

Ms. Youssouf asked if it is correct that the report states that 66 percent of the total payment has been recovered. Mr. McKenna replied that that was correct. Ms. Youssouf asked about the remaining piece of it. Mr. McKenna said that they are pursuing legal action; that they are not allowed to recoup it through payroll. It's a New York State Law. He believes that the law will change in November, but for this year they are not allowed. Dr. Stocker asked if the part that was recovered was on a voluntary basis. Mr. McKenna said yes, but the rest of the people declined to cooperate.

Ms. Barbara Keller, Deputy Counsel added that that was correct.

Mrs. Josephine Bolus asked if they envision the court telling them that they have to pay it back. Mr. McKenna responded yes.

Dr. Stocker asked if any of the people who owed money are still employed by HHC. Mr. McKenna replied yes, all of them. Ms. Youssouf asked why they would want to keep them. Ms. McKenna responded that they are trying to get legal guidance on how to force them to repay, the majority of the argument is that they say it is not their fault and because the law protects them, they don't have to repay it.

Mr. Antonio Martin, SVP/Chief Operating Officer asked how much money is involved. Mr. McKenna stated about $80,000, and that there are two different sets of overpayments. They collected 70 percent of it, the original amount was about $340,000 and have collected $200,000 almost $300,000. Dr. Stocker asked if they are all physicians. Mr. McKenna said no. Dr. Stocker asked how many people. Mr. McKenna said that it is about 40 people for $80,000. It is roughly $2,000 each and some of them are physicians.

Dr. Stocker stated that he did not expect it to take this turn that he always thought they were quite advanced.

Mr. Martin added that he did not know and he would follow up.

Dr. Stocker asked Mr. McKenna if he was a representative for all of PAGNY. He responded no, just for PAGNY at Harlem. Dr. Stocker also asked him if this is a problem at other facilities. Mr. McKenna said that he was not aware.

Mr. Telano continued with his update and stated that there were two other issues that were noted on the report. During the review of the payroll process, we found that PAGNY management did not always obtain approval from the Joint Oversight Committee for staff members that were hired to work at the facility. This occurred during the calendar year 2011. He believes that procedures have been put in place to ensure this does not occur in the future. The other issue noted was timesheets were found to be inaccurate, incomplete and not maintained. Thirteen percent of the timesheets we requested could not be found. We requested 415 timesheets during our review and 52 could not be located. Some of the other issues related to timesheets were that sessional and regular hours were not shown properly and that the hours that were indicated did not always equal to the amount of pay.

Ms. Youssouf asked if that was true and was there a Breakthrough. Mr. McKenna responded that there is an ongoing Breakthrough. Since the dual payroll system was implemented, there have not been any other issues.

Ms. Youssouf asked if this is the only facility associated with PAGNY having this problem. Mr. McKenna said that this is the only one that had the big transitional problem. Because of the Columbia exodus, it created many vacancies and that there was a lot of openings and hiring at one time. Mr. Martin added that the other PAGNY hospitals are much more stable.

Dr. Stocker asked Mr. McKenna what the reaction of the staff would be to an automated system. Mr. McKenna responded that on the doctor's side, very negative, but the rest probably would not be concerned about it. A lot of them don't even want to get on the email system.

Mr. Telano continued on with the next audit -- Representative Payee Program at Dr. Susan Smith McKinney Nursing and Rehabilitation Center. He asked the representatives from McKinney to approach the table. They introduced themselves as follows: Anthony Saul, Senior Associate Director, Julian John, Chief Financial Officer, David Dyer, Chief Financial Officer, Kings County Hospital and Glenford Hall, Compliance Officer at McKinney. Mr. Telano stated that we found that the monitoring of the residents' bank accounts was not adequate. This conclusion was based on the following findings:

- One resident did not receive any Social Security payments for two years.
- One resident's bank account balance exceeded the maximum allowable.
- One beneficiary who had expired, payments were still being received from Social Security.
- Six beneficiaries still had funds in their accounts, although they had expired.

The requirement is that the funds must be turned over to the beneficiary's estate. During the course of the audit, management was very proactive in taking measures to correct all the issues. As we brought up the findings on a daily basis, they reacted to them immediately.

Ms. Youssouf asked if the funds from Social Security go into their personal account. Mr. Telano said that the majority of it goes to the fees that are paid to the nursing home and the balance goes to the allowance account which is $50.00.

Ms. Youssouf asked the representatives if they're comfortable the problem is fixed. Mr. Saul responded yes, every year they are required to certify that these are their residents. Through Breakthrough they have developed a methodology that has a tickler system. Aside from us working at the listing, Patient Accounts is also going to verify that those dollars come in. Ms. Youssouf stated that that sounds great.

Mrs. Bolus asked who gets the excess funds that the patient receives from SSI. Mr. Saul replied that there is a limit on the amount of dollars that stays in the SSI account. They have what they called Performance Improvement Project, which they do on a monthly basis. When an individual's account reaches $1,500 we advise them that they need to move the money to another account.

Mrs. Bolus wanted to know what happens if the patient is not coherent and is getting custodial care. Mr. Saul said that a social worker is assigned to that individual and the representative of that individual. We have monthly meetings with the family members that actually take care of the resident. Mrs. Bolus asked what if there are no family members. Mr. Saul responded a patient advocate.

Ms. Youssouf asked if HHC has to refund any money to Medicaid or Medicare. Mr. Saul said that once they certified that the resident was theirs, they got a lump sum for Social Security. Ms. Youssouf stated that she is glad to hear that they corrected the little glitches and is looking forward to re-auditing them next year.

Mr. Telano then turned to the same audit done at Gouverneur Healthcare Services. The first issue has to do with the overall lack of control over the accounts. The cash on hand was higher than the amount the records stated. One resident received the maximum allowable amount of cash disbursement. Ten residents had no receipt on file for funds distributed and for the monthly reconciliation of the accounts; there was no indication of management review or approval. We also noted that the bank accounts established for the residents were not reviewed by Finance on a regular basis resulting in discrepancies in the records of Amalgamated Bank and the facility. Amalgamated Bank had, according to their records, 18 additional open bank accounts for residents who had expired. Also noted is that direct deposits for two residents were going into the main patient property account instead of their individual accounts, and that a resident who expired in 2009 still had $1,300 in their account. Lastly, we noted a segregation of duties issue that has one person being responsible for receiving, paying and distributing partial cash refunds, entering the transactions into the sub ledger and would take cash to the bank for deposits. Obviously, having one individual responsible for the entire process provides the opportunity to commit fraud.

Ms. Youssouf asked what the corrective action is. Mr. Telano said that everything was in place and that by implementing management review of the reconciliations and the bank accounts it took care of 75 percent of these issues.

Mr. Telano continued with the Audit of Patient Account Cancellations at Kings County Hospital Center. This is when a patient is admitted, but later determined that the admission was not medically necessary and the admission

is cancelled. Cancelled admissions can also occur when ambulatory surgery procedures are incorrectly processed as an admission. We found that the way the ambulatory surgery admissions were being processed, when they were cancelled were done processed differently from other cancelled admissions. Other cancelled admissions indicated a review of the patient chart or electronic medical record, and a second review by a physician advisor. Ambulatory surgery cancellations did not have this multiple review process and it was corrected. New policies and procedures were issued to address this issue.

Ms. Youssouf asked if the CFO from Kings was present. Mr. Telano responded yes and asked the representatives from Kings to approach the table and introduced themselves as follows: Dr. Maureen Beverly, Care and Case Management; Julian John, Chief Financial Officer; William Swenson, Deputy Chief Financial Officer; Danielle Downer, Sr. Health Care Analyst.

Ms. Youssouf asked them to explain what the waiver is and whether they have decided to apply for it. Mr. John stated that about a year and a half ago the Corporation had decided to apply on behalf of all facilities with need for waiver. It ended up that the facilities had to apply on their own, Coney Island and Bellevue have done it, but they assumed that since it was going to be done on a corporate level they would wait for a response from the Corporation. Since the audit, they have met with a team and have agreed that they should pursue establishing an observation area.

Dr. Stocker stated that he was under the impression that the Corporation had applied and asked how many facilities have it. Mr. John replied four facilities have it. Ms. Youssouf asked if the Corporation had decided not to pursue a waiver corporately.

Mr. Martin stated that it is more critical at other facilities, in some facilities there was not a pressing need. He thinks that the Corporation should revisit the issue and that it probably makes sense for the Corporation to make sure that all collectively have it.

Ms. Youssouf asked if he sees the Corporation having it individually. Mr. Martin responded yes that they are looking to have it corporate wide, but a decision was made to let the individual facilities make that decision themselves.

Mrs. Bolus asked where they are planning on doing the observation since there is no room in the emergency room. Mr. John said that it does not have to be in the Emergency Department; that it could be outside. He said that there is a State regulation and Federal regulation. The Federal regulation allows the facility to have a visual observation unit anywhere you want to within the Emergency Department whereas the State mandates to have something separate. He said that the State will be shifting to the Federal regulation. If it happens, it will probably be less expensive for the facility to implement an observation unit.

Ms. Youssouf stated that she does not understand what a waiver is. Mr. Martin said that there are admissions and then there are cancelled admissions. The observation unit is somewhere in-between. They can have somebody there for 23 hours then they can sort of observe them and then make a decision either to admit or not to admit. He believes that there has to be some sort of a waiver to actually get to that sort of thing. Ms. Youssouf then asked if they have to have an observation unit to get the waiver. Mr. Martin responded that they had to apply for the waiver to get to have an observation unit.

Mr. Swenson stated that in New York State, there is an eight hour rule where they must extend the patients beyond eight hours. This is where they have the waiver.

Mr. McNulty added that that was correct, they have to admit the patient within eight hours. Therefore if they get a waiver, they can hold the patient in one of the observation units for a longer amount of time. Mr. Martin added not to exceed 24 hours; these are mainly heart patients where they have to do procedures on them and it has to be done intermittently over the course of 24 hours.

Mr. Telano asked if there were any questions then continued with his presentation. The IT review of the GHX System, the objectives of the audit were to obtain an understanding of the application and the general controls of GHX. One of the issues we found was that user access controls need to be improved. We found that terminated users were still active on GHX application user logs, that passwords did not have an expiration date, there were no maximum level of authentication failures that lock the user access to the GHX application and password strength does not comply with HHC's information systems password policies and procedures. The other issue noted was that there was different pricing sometimes listed within GHX exchange regarding the Purchase Order price. This was due usually to timing issues in which the vendor had never updated their price on a timely basis and the limit of the contract did not coincide with vendor updating the prices. As a result, the invoice price differed from the price of the contract that was in the system and the vendor price.

Ms. Youssouf asked if the Corporation lost money. Mr. Telano replied that he had representatives that could answer her question. He asked the representatives to approach the table and identify themselves, they did as follows: Joseph Quinones, Sr. Assistant Vice President for Contract Administration and Control; Richard Olah, Sr. Vice President for Contracts; Franco Sagliocca, Director of Procurement Systems and Operations.

Mr. Quinones stated that Mr. Sagliocca runs the GHX system and that the Corporation does about $160 million in pharmacy. The Corporation has tens of thousands of billing of re-bills of these lags in contract renewals. They perform audits of that contract and also do audits for med / surg products. If at anytime that ultimately does not reconcile to a re-bill, it is captured to get that money back.

Ms. Youssouf asked how often these audits are performed. Mr. Quinones said that every year on an annual basis. Ms. Youssouf asked if it's a Q & A audit. Mr. Quinones responded that that was correct. Mr. Olah added that on a monthly basis they now carry a report of the contract exceptions and are resolved continually on a monthly basis. Mr. Quinones stated that any point in time that an audit is done they are going to see these variations between contract prices. Dr. Stocker asked that if the contracts were entered right away, would there be fewer issues. Mr. Quinones said that they have multiple entry points for a contract, for those contracts that are direct, HHC contracts with the supplier they go over those. For group purchasing, which they do a substantially, they are not in total control of those contracts whether or not in pharmacy.

Dr. Stocker asked is it because HHC does not have an adequate system to monitor or because of the contractual relationship. Mr. Quinones answered that right now they do Minnesota Multi State. On the pharmacy side, they do Premier, Novation and Med Assets. They have so many different access points in terms of requirements contracts that they really do not have to do anything other than to do an audit and make sure they reconcile.

Dr. Stocker asked if there is a variation between vendors. Mr. Quinones said that they have not found any and he thinks that they do a very good job over the years and they do a very good job trying to reconcile. There is a lot of software developments that have occurred that have really minimized. He added that they are below the benchmark for the most part, as long as there is a contract in place.

Dr. Stocker asked if there is a difference between HHC group purchases. Mr. Quinones responded absolutely that they have total control on the contracts they load. They are loaded on time therefore they have very little variation.

Ms. Youssouf inquired about the access controls and why terminated employees are not disengaged from the system. Mr. Quinones said that unfortunately they are not in complete control of that. They don't know when an employee has resigned from the Corporation or been terminated. Unless the facility notifies them, it is difficult for them to know who left, but they are trying to get a handle on it. Mr. Martin added that this a Corporate wide issue, it's with GHX, with e-mail and ID cards. The Corporation needs to make sure that all of their employees leave service through Human Resources and then HR can notify all the other departments. Dr. Boufford added that the procedure should be that you come in through HR, you go out through HR.

Dr. Stocker asked if the PeopleSoft system solves this problem. Mr. Quinones said that for that to work there would have to be some interfaces that would have to be done through PeopleSoft and their system and no one has talked to them about it. Ms. Youssouf asked about the expiration dates for passwords. Mr. Quinones replied that GHX system was fully implemented about 11 months ago so they welcome the audit to inquire about GHX. In the management's response to the first category of systems checks that were done, three through six will require system enhancements through GHX. Ms. Youssouf requested to let the Committee know what these enhancements are.

Mr. Telano continued with the Petty Cash Audit at Queens Hospital Center – he stated that they found very minor issues. The first one being, that some of the expenses exceeded the limit of $50 which is required by the Operating Procedure. The other one was a recommendation that in some instances staff members use credits card then requested to be reimbursed by petty cash. That contradicts the purpose of petty cash.

Mr. Telano stated that listed are the four Affiliation Audits that were done. Primarily, there were record keeping issues found at NYU at Woodhull, NYU at Bellevue and also Mount Sinai at Queens. The only issue noteworthy was the audit in which it was found that the recalcs were not completed for fiscal year 2010 or 2011 as of the date of the audit at Coler Goldwater and Roosevelt Island Medical Associates. He believes that as of this date they are both in draft form.

Ms. Youssouf went back to item number three – IT Review of the GHX System and asked if the employees who have been terminated for 130 to 472 days and still had access to the system – were they still getting paid. Mr. Telano replied no.

Dr. Stocker stated that he did not understand how employees at the Woodhull/NYU can sign different time sheets and get paid since they know what the signature is supposed to look like. Mr. Telano responded that he did not have an answer for that. Dr. Stocker asked if there were any representatives from Woodhull, Mr. Telano said no. Dr. Boufford added that NYU Affiliate manager needs to be a little bit more proactive and asked if we could get a better response from management. Ms. Youssouf said that she thought it was a good idea and asked Mr. Telano to look into that.

Mr. Telano continued where it lists the Auxiliaries audits that have been done by the CPA firm of Loeb and Troper. Very minor issues were found. Dr. Stocker stated that out of 17 auxiliaries and all this is pretty good.

Mr. Telano turned to where the audits in progress are listed. He noted that what is not listed are the four Purchasing Audits which are in progress. They are at Kings, Jacobi, Bellevue and Lincoln. The last page lists the status of all the audits and if there are no other questions that concludes his presentation.

Mr. Wayne McNulty, Corporate Compliance, saluted the Committee and asked them turn to page three of the Corporate Compliance Report. Starting with Section one, compliance training, he informed the Audit Committee (the "Committee") that he previously reported that the Office of Corporate Compliance ("OCC") instituted an internally developed compliance computer-based training for physicians. He added that the module went live in June (2012). He informed the Committee that the OCC was currently developing modules for the Board of Directors and nurses and other health care professionals. He stated that these modules were expected to be completed within a couple of weeks. He highlighted that the training content was developed and would be transferred to a learning computer-based system. He asked if there were any questions about the compliance training.

Mr. McNulty continued with item number two, the calendar year 2012 Corporate Compliance Work Plan Status Update. He informed the Committee that three (3) items were closed in the last couple of months. He told the Committee that he expects that several more items will move into the mitigation and monitoring cycles. He noted that there was three (3) additional items that are being reviewed for closure, which he said would be discussed at the next Committee meeting. He asked if there were any questions about the work plan or any other item.

Mr. McNulty moved on to item number three, the United States Department of Health and Human Services ("HHS") released its 2012 work plan. He and his staff determined that 49 items on that work plan were applicable to HHC; he told the Committee that a vulnerability assessment of all of those items was being conducted to determine if HHC has any risk present. He said OCC's determination would be reported to the Committee. Mr. McNulty explained that questions are sent to the various process and operational experts throughout the facilities. He added that most of the responses have been received and corresponding risk scores were being calculated. He further explained that the resulting risk scores determine whether or not there is a high level of risk, moderate risk or low level of risk present.

Mr. McNulty went to item number 4, Compliance Index. He stated that from January (2012) to June (2012) the OCC had 256 compliance based reports. Out of those reports, 12 were considered Priority A matters that required immediate review or action due to an allegation of an immediate threat to a person, property or the environment; 91 Priority B matters were present, which are matters of a time sensitive nature that may require department review and action. He told the Committee that the remaining 153 reports were Priority C matters. He stated that Priority C matters were matters that did not require immediate action. He added that out of those reports, about half, or 134 were received directly through the hot line. He stated that the OCC received 40 by telephone, 42 face-to-face, and 25 by e-mail.

Ms. Youssouf wanted to know that if out of the reports he received, is there was anything of note that the Committee should be aware of and was an investigation performed. Mr. McNulty replied yes, they performed an investigation on all the reports they received. Mr. McNulty cautioned the Committee that some of these investigations were still pending and could not be discussed in a public forum. He stated that some of the complaints were referred to the HHC Inspector General ("IG") if they involved conflicts of interest or any criminal activity. He stated that sometimes the IG refers these same items back to the OCC for investigation. He added that some of these matters actually go through the Conflict of Interest Board of New York City. Then they are referred to the Department of Investigation, who in turn refers them back to HHC for investigation. Ms. Youssouf asked if a matter existed that the Committee should be alerted to, would it be discussed at an Executive Session of the Committee. Mr. McNulty replied yes and Ms. Youssouf stated to please let them know when they should have one. Mr. McNulty responded absolutely and recommended that at the next Audit Committee meeting he would like to address all of the Priority A reports since they pose an immediate threat.

Dr. Boufford suggested that the OCC look for patterns in the reports received, which might indicate a target for an audit or some other managerial action. She also asked if Mr. McNulty expected compliance reports to go down or up. Mr. McNulty said that during the same point last year, they had 262 compliance based reports and he thinks that the more education performed by his office, the more calls his office will receive. With respect to the nature of the calls, Mr. McNulty stated that the OCC received a lot of calls from patients as a result of the compliance fliers posted. Mr. McNulty stated that he looks forward to reporting the compliance reports in detail when the Committee convenes in Executive Session. He closed by noting that he contacts the President, Chairman, and also the Committee Chair when he receives Priority reports of a serious nature.

Mr. McNulty moved on to Section five by stating that the OCC also has a system for investigating privacy complaints. Mr. McNulty stated that during the first half of this year, the OCC received 38 complaints related to HIPAA. He told the Committee that one complaint, in April of 2012, involved a physician at Queens Hospital Center who reported the theft of three thumb drives containing protected health information. He commented that there was information pertaining to 42 patients on the stolen drives. He informed the Committee that each of these patients had to be contacted because the OCC determined that the breach in the information contained on the drives was a significant risk of financial, reputational or other harm to the affected patients. Dr. Stocker asked if he had any evidence that anybody used the information. Mr. McNulty replied no, not at this time. Dr. Stocker asked if the drives were encrypted or password protected. Mr. McNulty said that to his knowledge no, but IT has instituted a Corporate-wide system that prohibits the downloading of information from the desk top computers of employees to a thumb drive unless encryption is in place. At this point, 45 percent of the Corporation's systems are encrypted for these purposes.

Dr. Boufford asked if this was an IRB process under Medical and Professional Affairs. Mr. Martin added that it is in Medical and Professional Affairs. Mr. McNulty said that the subject matter, to his knowledge, did not relate to research information. Mr. Martin said that it was one of the HHC physicians who is very proactive in terms of denial and rebutting denials. He had the information because he wanted to try to get money for the facility. He left the thumb drives in the car trying to do the right thing. Mr. McNulty said that as a result of the subject incident, the physician was retrained; there was a Town Hall meeting conducted at the facility by the senior compliance officer; and several individuals at the facility were educated on the relevant policies and procedures.

Mr. McNulty continued with item six, Staffing Update. There are two vacancies in the OCC. He commented that one of the vacancies was at the North Bronx Healthcare Network; he expected for that position to be filled by Friday (September 28, 2012) or Monday (October 1, 2012). He stated that there was also a vacancy in the Central Office, OCC. He told the Committee that this compliance officer would be placed in the South Manhattan Network once the approval process for this vacancy is complete.

Mr. McNulty continued with item seven, Data Mining Compliance Activities. He stated that the OCC's staff members were undergoing Siemens data GPS training. He told the Committee that the Office of Revenue Management has provided this training to all staff members, who will have access to the entire patient data warehouse. He commented that this would help the OCC look at different outliers in terms of whether or not HHC has risk in certain areas with respect to complaints and so forth.

Ms. Youssouf asked if this is something that Internal Audits uses that it could be helpful in terms of audits. Mr. McNulty answered that they actually talked about such training. Mr. Telano added that he did not know yet, but he has requested training and have had conversations regarding this and it was recommended that training should be

done separately. Mr. Telano added that he has initiated contact with Revenue Management and have a training scheduled.

Mr. McNulty moved on to item number nine, Third Party Health Insurance Recovery Activity. He started by stating that in late July, his office and the Office of the General Counsel were contacted by the Medicaid Inspector General with regards to recovery activities as it relates to overpayments where Medicaid was billed but was not the payer of last resort. The communications stated that that there was a delay in HHC reconciling and paying refunds of over $3 million to the Office of the Medicaid Inspector General ("OMIG"). OMIG also requested that the OCC provide them with information regarding the OCC's policies and procedures relating to recovery activities as described under New York's mandatory compliance program regulations. Mr. McNulty stated that his office responded to OMIG by outlining its compliance policies and procedures regarding overpayments; and explaining that the delay in question was in part due to HHC's need to ensure that the requested payments to OMIG did not duplicate amounts that HHC already paid to managed care organizations ("MCOs") or did not otherwise fall into the MCO's time, to seek recovery of the third party health insurance amounts. Mr. McNulty added that he underscored HHC's commitment to work closely with OMIG and to streamline its process. Then he emphasized that the OCC would take a look at HHC's policies and procedures related to overpayments depending on the outcome of the investigation. Mr. McNulty asked if there were any questions about the third party health insurance recovery activities.

Mrs. Bolus asked when he expects an answer from them. Mr. McNulty replied that he did not hear back from OMIG, noting that he attempted to contact Matthew Babcock, the head of OMIG Compliance, earlier in the day, but he did not hear back from him as of yet. He added that the response to OMIG was very thorough; that HHC outlined to OMIG its numerous policies and procedures with regard to overpayments. He said that based on the outcome, HHC may have to supplement its overpayment policy. He told the Committee that although a draft federal regulation that addresses overpayments exists, the OCC may have to wait for said draft to become final so that it can implement policies based on that regulation.

Mrs. Bolus asked if he agrees with the amount. Mr. McNulty stated that HHC does not agree with the amount because in certain instances HHC already gave Managed Care Organizations payment. He stated that there is money that has to go back to OMIG, but they have not reconciled the $3 Million. Ms. Youssouf asked if there is any kind of provision that if HHC does not pay them at a certain time that they charged interest. Mr. McNulty replied that he was not aware of such a provision. Ms. Youssouf suggested that should be checked. Ms. Bolus asked if this has happened before. Mr. McNulty said that this is the first time he's been informed and it is not rare that they have overpayments, but probably not in the amount of $3 million.

Mr. McNulty moved to item number 10, stating that he and his deputy were interviewed by KPMG as part of KPMG's review and management letter. Mr. McNulty stated that the OCC looks forward to hearing KPMG's review of HHC's compliance program. Mr. McNulty moved on to OCC's review of the use of patient white boards throughout HHC. He explained that this review was being conducted to determine compliance with the confidentiality provisions of HIPAA, CMS, and also New York State Law. Mr. McNulty told the Committee that he visited every acute care facility to take a look at how they operate patient white boards. Mr. McNulty described the appearance of patient white boards, as well as the content of patient information contained on patient white boards, to the Committee, and stated that each acute care facility utilized patient white boards. Mrs. Bolus stated that that is a lot of information and anyone can on the floor and see it. Ms. Youssouf asked if he knew of other facilities that have it. Mr. Martin replied that most of the facilities have white boards because it is very helpful in a very busy Emergency Room. Mr. McNulty said that the physicians found it very helpful they are able to look at the board and understand everything that is going on with regard to the patients.

Mr. McNulty continued with item number 13, Environmental Compliance Activity. He alerted the Committee that over the past nine months, five HHC facilities were subjected to environmental compliance related surveys by City, State, or Federal environmental protection agencies. He elaborated that, in December (2011), Lincoln Medical and Mental Health Center ("Lincoln") underwent review by the EPA; in May (2012), Bellevue underwent review by the Department of Environmental Conservation; and in May (2012) Elmhurst underwent review by the Department of Environmental Protection. Mr. McNulty continued by stating that, in June (2012), Coney Island was reviewed by the EPA; and in July (2012), Metropolitan was surveyed by the Department of Environmental Conservation. Mr. McNulty explained to the Committee that the environmental compliance activities at HHC were covered partly by four different offices: (i) the OCC; (ii) the Office of Facilities Development; (iii) the Office of Legal Affairs; and (iv) the Office of Operations. He told the Committee that these offices recently met in an attempt to come up with a solution to streamline the way environmental compliance activities are addressed at HHC. He added that, as a short term solution, each facility compliance committee will perform audits with respect to environmental compliance as it relates to the areas that the City, State and Federal agencies were looking at. He added that, for a long term solution, one person throughout the Corporation will be responsible for overseeing HHC's environmental compliance activities. Mr. Martin added that Roz Weinstein, Sr. Assistant Vice President is going to coordinate these activities. Each of the networks has designated a point person so they do not have to go to 70 different people regarding the plan of correction. Ms. Youssouf asked if there is any particular institution that had a problem. Mr. McNulty replied that four out of the five facilities surveyed had to institute a plan of correction. Ms. Youssouf asked if it was primarily underground storage tanks. Mr. McNulty answered yes, but then elaborated that the only facility that did not receive a citation was Elmhurst. He stated that although regulatory bodies reviewed Coney Island Hospital and no citation was issued, Coney did receive recommendations with regard to waste management and a citation may still be forthcoming. He stated that the Metropolitan survey dealt with underground storage tanks; the Lincoln survey dealt with waste management; and the Bellevue survey dealt with underground storage tanks. Ms. Youssouf asked who deals with that at the facilities now. Mr. McNulty responded that environmental services does, noting that environmental services is usually under operations or facilities management.

Mrs. Bolus added that missing from Mr. McNulty's list is Coler; she stated that Coler had tanks underneath that had to be removed. Mr. Martin stated that they still have to make sure the tanks are clear and would remediate everything and he thinks that they moving in the right direction.

Mr. McNulty stated that if there were no further questions that concludes his report.

Dr. Stocker asked Mr. McNulty if he had the resources to get through the 48 audits in a reasonable period of time. Mr. McNulty replied that in Calendar Year 2013, the facilities will perform self-identification of risks. He continued stating that once the top priority risks are identified, they would be added to HHC's Work Plan.

Mrs. Bolus asked if the only vacancies are at Queens. Mr. McNulty replied that the OCC had a vacancy at the North Bronx Healthcare Network, which he expected to fill by Friday (September 28, 2012) or Monday (October 1, 2012). Mr. McNulty noted that there was an additional compliance officer vacancy at the South Manhattan Healthcare Network. Dr. Stocker asked Mr. McNulty if the OCC's current audit plan was consistent with the amount of Corporate resources on a whole. Dr. Stocker queried whether HHC would fall behind with its current audit plan. Mr. McNulty responded that he did not think HHC would fall behind. Mr. McNulty added that many of the work plan items have more than one remediation stage. He explained that the initial assessment for these items may have shown that risks were present. As a result, he continued, plans of correction were being developed. Mr. McNulty, providing an example, stated that the Radiology Compliance item would be on the work plan this year and probably the following year. He explained that over 300 questions were developed for that particular work plan item. He

added that his office has met with the Radiology Council, which meets every month. Mr. McNulty closed by stating that all of the work plan items were being worked on.

Ms. Youssouf asked if there were any old business or new business.

There being no further business, the meeting was adjourned at 4:21 P.M.

Submitted by,

Emily Youssouf
Chairperson
Audit Committee

AUDIT COMMITTEE OF THE HHC BOARD OF DIRECTORS

Corporate Compliance Report

December 6, 2012

Table of Contents

I. Compliance Training

- The content for the Nurses and Health Professionals compliance computer-based training ("CBT") module has been completed and will go live within the next week.
- The content for the HHC Board of Directors CBT module has been completed and is ready to go live.
- The content for the General Staff CBT module (Group 11 employees and designated Group 12 employees) has been completed and will go live within a week

II. CY 2011 Corporate Compliance Work Plan Status Update

A. Closed Work Plan Items

Over the past twelve months all 40 CY 2011 Corporate Compliance Work Plan items were continuously worked on. Nine items are now considered "Closed" or "Closure Pending" by the OCC. (Note, an item is considered closed or closure pending when it has met all standards of review). Official closing reports for all of these items are being prepared and will be provided to Audit Committee over the next several weeks.

The following nine items are now closed or closure is pending:

- LCSW/LMSW Counseling Documentation
- Home Health Claims Review
- Hospital Readmissions
- Provider-Based Status for Inpatient ("IP") & Outpatient ("OP") Facilities
- Payments for Polysomnography
- Billing of Portable X-Ray Suppliers
- Patient Review Instrument Clinical Audit
- Criminal Background Checks at Nursing Facilities
- Low Birth Weight DRG

Out of the remaining thirty-one items, ten are either entering in or presently in the mitigation phase and four items are currently in the monitoring phase where corresponding plans of correction are being assessed for effectiveness. Seventeen items remain in the assessment phase. One item, Replacement of Medical Device Claims, was moved from a Network specific item to a Corporate-wide item due to its broad applicability and level of risk.

III. HHC CY 2012-13 Corporate Compliance Work Plan & Status Update & Summary of Past and Present Work Plan Items

- The HHC CY 2012-13 Corporate Compliance Work Plan is expected to be released this week. Once released, this Work Plan will remain in effect until June 30, 2013. On July 1, 2013, the OCC will introduce HHC's FY 2014 Corporate Compliance Work Plan.

IV. Compliance Index

- For the third quarter of CY 2012 (July 1st through September 30th), there were 144 compliance-based reports of which 11 were classified as Priority "A" reports, 56 as Priority "B" reports, and 77 as Priority "C" reports. For purposes here, the term "reports" mean compliance-based inquiries and compliance-based complaints.

- Of the 144 reports received in this past quarter of CY 2012, 89 (or 61.8%) were compliance complaints received on the OCC's anonymous toll-free compliance hotline.

- Attachment "1" provides a graphic representation of the compliance reports described above.

Summary:

1) Report Classification

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

2) Reporting Source Analysis

Of the 144 reports received in the third quarter of CY2012, there were 89 (or 61.8%) compliance complaints received on the OCC's anonymous toll-free compliance hotline; 17 complaints (or 11.8 %) received Face to Face; 14 complaints (or 9.7%) received via E-Mail; 15 (or 10.4%) complaints received via Telephone; 3 complaints (or 2.1%) received via regular Mail; 2 complaints (or 1.4%) received Web Submission; 2 complaints (or 1.4%) received via Other methods; 1 complaint (or 0.7%) received via Interoffice Mail; 1 complaint (or 0.7%) received via Referral from other HHC Office.

3) Allegation Class Analysis

Of the 144 reports received in the third quarter of CY2012, 53 (or 36.8%) complaints pertained to Policy and Process Integrity; 31 (or 21.5%) involved the category of Other; 28 (or 19.4%) pertained to Misuse or Misappropriation of Assets or Information; 16 (or 11.1%) involved Employee Relations; 8 complaints (or 5.6%) involved Diversity, Equal Opportunity and Respect in the Workplace; 5 (or 3.5%) pertained to Financial Concerns; 3 (or 2.1%) involved Environmental, Health and Safety issues.

V. Privacy Compliance Index

- During the period of July through September of CY 2012, 17 complaints were entered in the HHC HIPAA Complaint Tracking System, an HHC proprietary database. Of the seventeen (17) complaints entered in the tracking system eight (8) were found after investigation to be violations of HHC HIPAA Privacy Operating Procedures; two (2) were determined to be unsubstantiated; four (4) were found not to be a violation of HHC HIPAA Privacy Operating Procedures. The remaining one (1) complaint is classified as pending which means that it was under investigation during the timeframe of the reporting period. Attachment "2" provides a graphic description of the privacy compliance index.

VI. Reportable Data Breach

On June 1, 2012, the New York City Police Department ("NYPD") notified Woodhull Medical and Mental Health Center ("Woodhull") Hospital Police that it recovered 186 Unity System print outs pertaining to 190 Woodhull patients during the execution of a search warrant outside at an undisclosed residence. The printouts contained protected health information ("PHI") including the following: name; address; telephone number(s); social security number; medical record number; health insurance information; treatment information; and birth dates. Notification was made to the Office of Corporate Compliance ("OCC") as well as the HHC Office of the Inspector General ("OIG"). Through the OIG, NYPD requested that a law enforcement delay be put into effect so that a complete investigation could be conducted prior to notifying the affected patients of the breach. Through written correspondence dated October 1, 2012, the OIG informed the OCC that the investigation had been concluded and breach response procedures may begin. The OCC received this correspondence on or about October 9, 2012.

HHC Office of Legal Affairs ("OLA") determined that a significant risk of legal, financial or other harm to the affected patients existed and as such, the OCC has obtained the services of a vendor to assist in the breach notification process as well as to provide credit monitoring and identity restoration service to those affected by the breach. The contract was finalized on November 28, 2012. It is anticipated that the breach notification process will begin on or before December 7, 2012.

VII. OCC Staffing Update

- The OCC has the following two (2) vacant compliance officer positions: (i) a deputy compliance officer position at Central Office; and (ii) an associate compliance officer position at the South Manhattan Healthcare Network. The recruitment process for these positions has begun. Both vacancies are expected to be filled by the end of the second week of December.

- NO FURTHER TEXT ON THIS PAGE -

VIII. Monitoring of Excluded Providers

- No self-disclosures related to the use of excluded providers were made to regulatory bodies since the last time the Audit Committee convened in September, 2012.

IX. OMIG Compliance Program Assessment

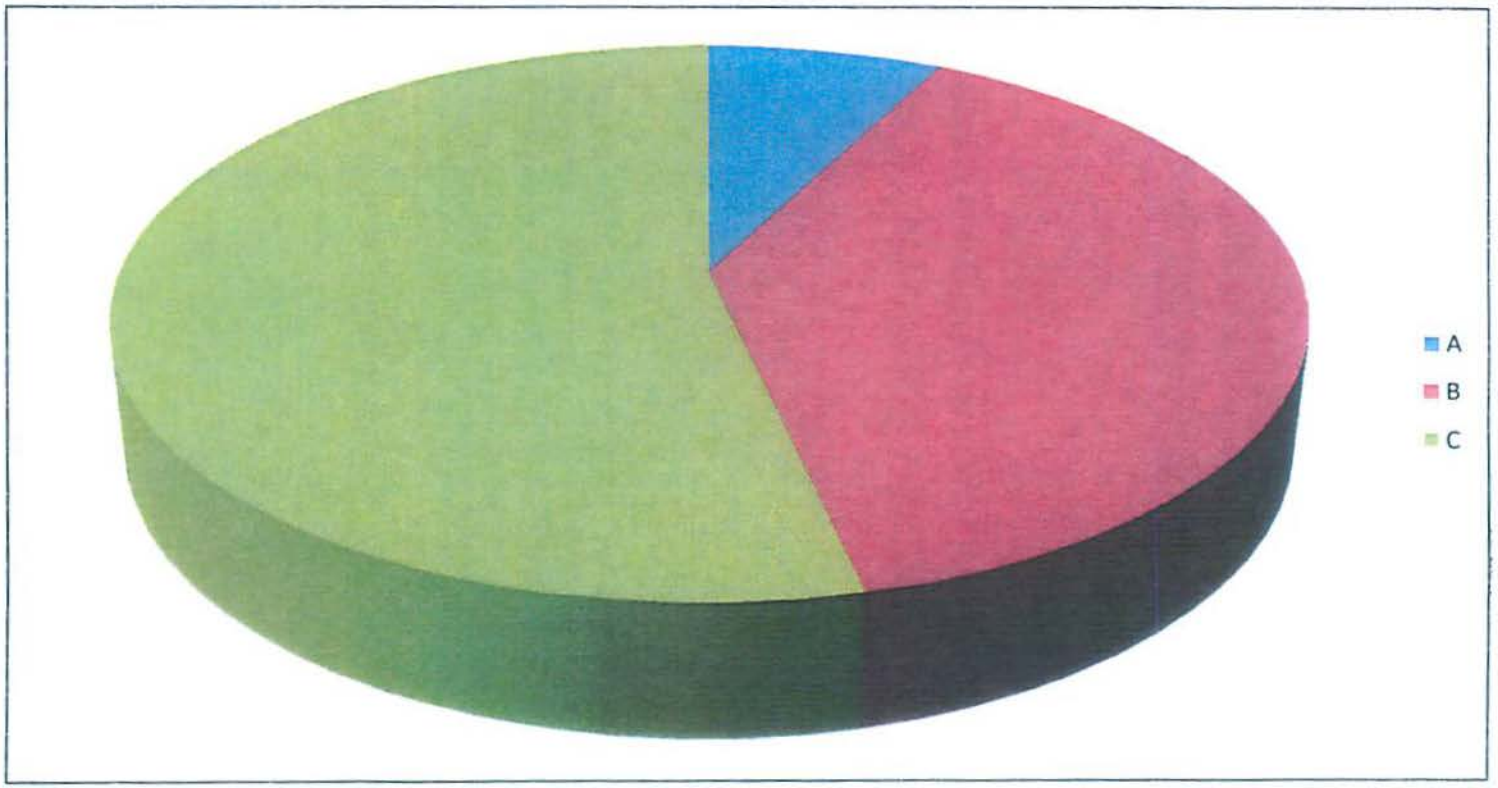
- Attached for discussion is the OMIG Compliance Program Assessment Form (*see* Attachment "3").

ATTACHMENT "1"

PRIORITY ANALYSIS

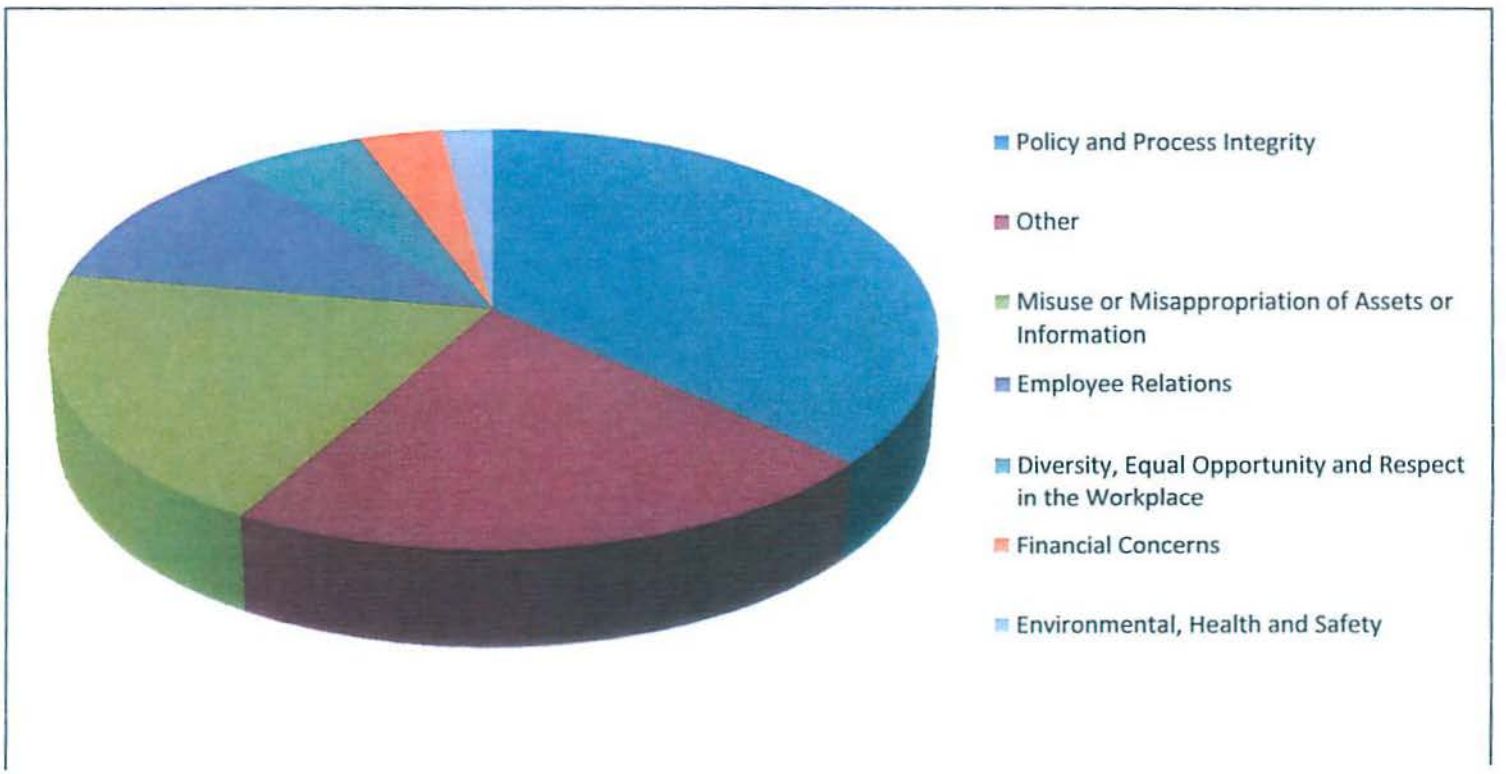
July 1, 2012 - September 30, 2012

	Total	Frequency (Percentage)
A	11	7.6
B	56	38.9
C	77	53.5
Total	**144**	**100**



PRIMARY ALLEGATION CLASS ANALYSIS
July 1, 2012 - September 30, 2012

	Total	Frequency (Percentage)
Policy and Process Integrity	53	36.8
Other	31	21.5
Misuse or Misappropriation of Assets or Information	28	19.4
Employee Relations	16	11.1
Diversity, Equal Opportunity and Respect in the Workplace	8	5.6
Financial Concerns	5	3.5
Environmental, Health and Safety	3	2.1
Total	**144**	**100**

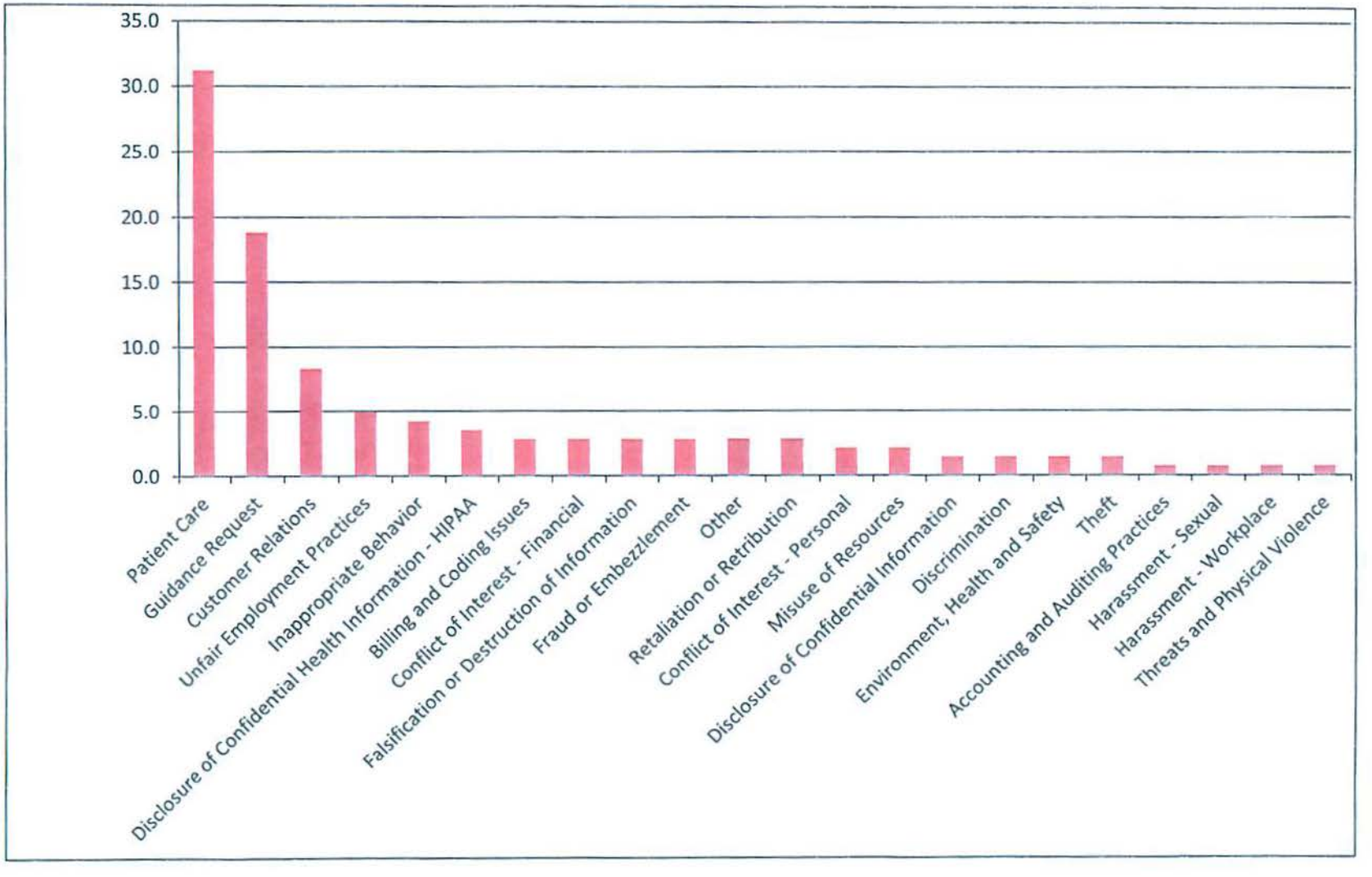


PRIMARY ALLEGATION TYPE ANALYSIS
July 1, 2012 - September 30, 2012

	Total	Frequency (Percentage)
Patient Care	45	31.2
Guidance Request	27	18.8
Customer Relations	12	8.3
Unfair Employment Practices	7	4.9
Inappropriate Behavior	6	4.2
Disclosure of Confidential Health Information - HIPAA	5	3.5
Billing and Coding Issues	4	2.8
Conflict of Interest - Financial	4	2.8
Falsification or Destruction of Information	4	2.8
Fraud or Embezzlement	4	2.8
Other	4	2.8
Retaliation or Retribution	4	2.8
Conflict of Interest - Personal	3	2.1
Misuse of Resources	3	2.1
Disclosure of Confidential Information	2	1.4
Discrimination	2	1.4
Environment, Health and Safety	2	1.4
Theft	2	1.4
Accounting and Auditing Practices	1	0.7
Harassment - Sexual	1	0.7
Harassment - Workplace	1	0.7
Threats and Physical Violence	1	0.7
Total	**144**	**100**

PRIMARY ALLEGATION TYPE ANALYSIS

July 1, 2012 - September 30, 2012



ATTACHMENT "2"

Office of Corporate Compliance

HIPAA Complaints*

07/01/2012 – 09/30/12**

Complaint Type	Number Reported	Violation Determination				Breach Determination		Patients Affected
		Pending	Not Substantiated	Violation Not Found	Violation			
Access	2	0	0	2	0	0	0	0
Confidential Communication	6	1	1	2	2	2	0	0
Disclosure	8	1***	1	0	6	6	0	0
Authorization	1	1	0	0	0	0	0	0
TOTAL	17	3	2	4	8	8	0	0

*HHC Facility Privacy Officers and Network Security Officers are required to report all potential HIPAA violations at their facilities/networks to the Corporate HIPAA Privacy Officer, Office of Corporate Compliance, and document all relevant details of the incident in the HIPAA Complaint Tracking system. All incidents are initially recorded as potential HIPAA violations. Upon investigation, a determination is made whether a HIPAA violation has occurred. HIPAA violations are further assessed by the Office of Corporate Compliance and the Office of Legal Affairs to determine whether the violation constitutes a HIPAA breach (i.e., significant risk of financial, reputational, or other harm) that requires notice to affected parties.

**Date reported incidents occurred.

***The disclosure violation categorized as "pending" was under investigation by the HHC Office of the Inspector General, the results of which concluded beyond the timeframe of this report.

ATTACHMENT "3"

New York State Office of Medicaid Inspector General
Bureau of Compliance

COMPLIANCE PROGRAM ASSESSMENT FORM

INSTRUCTIONS

1. Electronically complete the Compliance Program Assessment Form using MS Word.

2. Insert responses in appropriate fields.

3. Collect copies of all documents referred to in responding to the questions that are posed.

4. When completing the "Evidence of Compliance" column in the chart on the following pages, responses should include specific citations to the documents and text that support any "Yes" response. Specifically include:
   a. document name,
   b. page number and
   c. section of the text that supports your "Yes" response.

   It is not sufficient just to list the document that provides the evidence.

5. *Do not send the completed Compliance Program Assessment Form to OMIG unless specifically requested by OMIG.*

COMPLIANCE PROGRAM ASSESSMENT FORM

Name of Medicaid Provider:

Medicaid Provider IDS(s) #:

Federal Employee Identification Number

(FEIN) associated with Medicaid billings:

Person Completing Assessment:

Title of Person Completing Assessment:

Date Assessment Completed:

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	Element 1: Written policies and procedures						
1.1	Do you have written policies and procedures that describe compliance expectations in a code of conduct or code of ethics?						
1.2	Have you implemented the operation of the compliance program?						
1.3	Do you have written policies and procedures that provide guidance to *employees* on dealing with potential compliance issues?						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
1.4	Do you have written policies and procedures that provide guidance to *others* on dealing with potential compliance issues?			*Please define "others" as it relates to this Element.*			
1.5	Do you have written policies and procedures that provide guidance on how to communicate compliance issues to appropriate compliance personnel?						
1.6	Do you have written policies and procedures that provide guidance on how potential compliance problems are investigated and resolved?						
	Element 2: Designate an employee vested with responsibility						
2.1	Has a designated employee been vested with responsibility for the day-to-day operation of the compliance program?						
2.2	Are the designated employee's (referred to in 2.1) duties related solely to compliance? *If the answer to 2.2 is "Yes" indicate "NA" in 2.3 and continue on to 2.4. If the*						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	answer to 2.2 is "No" answer 2.3.						
2.3	If the designated employee's (referred to in 2.1) compliance duties are combined with other duties, are the compliance responsibilities satisfactorily carried out?			*Provide details on what the designated employee's other duties are and how you assess if the compliance duties are being satisfactorily carried out.*			
2.4	Does the designated employee (referred to in 2.1) report directly to the entity's chief executive or other senior administrator?			*Specify the reporting relationship.*			
2.5	Does the designated employee (referred to in 2.1) periodically report directly to the governing body on the activities of the compliance program?			*Specify the reporting relationship, the basis for the reporting relationship and the frequency of the reporting.*			
	Element 3: Training and education						
3.1	Is training and education provided to *all affected employees* on compliance issues, expectations and the compliance program operation?			*Please define affected employees used for purposes of training in this Element.*			
3.2	Is training and education			*Please define "affected*			

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	provided to *all affected persons associated with the provider* on compliance issues, expectations and the compliance program operation?			*persons associated with the provider "used for purposes of training in this Element.*			
3.3	Is training and education provided to *all executives* on compliance issues, expectations and the compliance program operation?						
3.4	Is training and education provided to *all governing body members* on compliance issues, expectations and the compliance program operation?						
3.5	Does the compliance training occur periodically?			*Please define the timing of the periodic training and the audience for the periodic training.*			
3.6	Is compliance training part of the orientation for *new employees*?						
3.7	Is compliance training part of the orientation for *appointees or associates*?						
3.8	Is compliance training part of						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	the orientation for *executives?*						
3.9	Is compliance training part of the orientation for *governing body members*?						

Element 4: Communication lines to the responsible compliance position

4.1	Are there communication lines to the designated employee referred to in item 2.1 that are accessible to *all employees* to allow compliance issues to be reported?						
4.2	Are there communication lines to the designated employee referred to in item 2.1 that are accessible to *all persons associated with the provider* to allow compliance issues to be reported?						
4.3	Are there communication lines to the designated employee referred to in item 2.1 that are accessible to *all executives* to allow compliance issues to be reported?						
4.4	Are there communication lines to the designated employee referred to in item						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	2.1 that are accessible to *all governing body members* to allow compliance issues to be reported?						
4.5	Is there a method in place for *anonymous* good faith reporting of potential compliance issues as they are identified for each group noted in items 4.1 through 4.4?						
4.6	Is there a method in place for *confidential* good faith reporting of potential compliance issues as they are identified for each group noted in items 4.1 through 4.4?						
	Element 5: Disciplinary policies to encourage good faith participation						
5.1	Do disciplinary policies exist to encourage good faith participation in the compliance program by all affected individuals? *For purposes of Element 5, "affected individuals" shall mean those persons who are required to receive training and education under Element*						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	3 above.						
5.2	Are there policies in effect that articulate expectations for reporting compliance issues for all affected individuals?						
5.3	Are there policies in effect that articulate expectations for assisting in the resolution of compliance issues for all affected individuals?						
5.4	Is there a policy in effect that outlines sanctions for failing to report suspected problems for all affected individuals?						
5.5	Is there a policy in effect that outlines sanctions for participating in non-compliant behavior for all affected individuals?						
5.6	Is there a policy in effect that outlines sanctions for encouraging, directing, facilitating or permitting non-compliant behavior for all affected individuals?						
5.7	Are all compliance-related disciplinary policies fairly and firmly enforced?						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	Element 6: A system for routine identification of compliance risk areas						
6.1	Do you have a system in place for routine identification of compliance risk areas specific to your provider type?						
6.2	Do you have a system in place for self-evaluation of the risk areas identified in 6.1, including internal audits and as appropriate external audits?						
6.3	Do you have a system in place for evaluation of potential or actual non-compliance as a result of self-evaluations and audits identified in 6.2?						
	Element 7: A system for responding to compliance issues						
7.1	Is there a system in place for responding to compliance issues as they are raised?						
7.2	Is there a system in place for investigating potential compliance problems?						
7.3	Is there a system in place for responding to compliance problems as identified in the course of self-evaluations and						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	audits?						
7.4	Is there a system in place for correcting compliance problems (as referred to in 7.3) promptly and thoroughly?						
7.5	Is there a system in place for implementing procedures, policies and systems as necessary to reduce the potential for recurrence?						
7.6	Is there a system in place for identifying and reporting compliance issues to the NYS Department of Health or the NYS Office of Medicaid Inspector General?						
7.7	Is there a system in place for refunding Medicaid overpayments?						
	Element 8: A policy of non-intimidation and non-retaliation						
8.1	Is there a policy of *non-intimidation* for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and						

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that supports any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	reporting to appropriate officials as provided in Sections 740 and 741 of the New York State Labor Law?						
8.2	Is there a policy of *non-retaliation* for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in Sections 740 and 741 of the New York State Labor Law?						

18 NYCRR §521.3(a) requires compliance programs to be applicable to the areas listed below.
For each question below please identify documentation to support each "Yes" response.

	Description	Provider Yes	Provider No	Provider's Evidence of Compliance or action required *Include specific citations to the documents and text that support any "Yes" response*	OMIG Yes	OMIG No	Bureau of Compliance Conclusions Based upon Responses from Provider
	Is your compliance program applicable to:						
(1)	Medicaid billings?						
(2)	Medicaid payments?						
(3)	the medical necessity and "quality of care" of the services provided to enrollees of the Medicaid program?						
(4)	governance of the provider, particularly as related to the Medicaid program?						
(5)	mandatory reporting requirements as related to the Medicaid program?						
(6)	credentialing for those who are providing covered services under the Medicaid program?						
(7)	other risk areas that are or should with due diligence be identified by the provider?						