NYC Health + Hospitals
Office of Corporate Compliance

DSRIP TRAINING
This training is intended for the educational use by NYC Health + Hospitals/OneCity Health ("OneCity Health") Performing Provider System ("PPS") Participants (or "Partners") and their respective workforce members who are involved or associated with, or otherwise affected by, the New York State ("NYS") Delivery System Reform Incentive Payment ("DSRIP") program. This presentation is designed to provide you with information specific to the OneCity Health PPS and related DSRIP compliance issues.

Partners are welcome to utilize this presentation to assist them in satisfying their obligation to comply with DSRIP compliance requirements. Notwithstanding, the ultimate responsibility to comply with DSRIP requirements and any related Federal or NYS law lies solely with each OneCity Health Partner.

This training is for educational purposes only and shall not be construed as legal advice. Specifically, the training provides general compliance education on a broad range of compliance topics; it is not intended to cover the nuance areas of the topics discussed.

OneCity Health Partners should contact the Office of Corporate Compliance ("OCC") if they have questions pertaining to a particular compliance issue.
Section 1

Introduction to DSRIP
What is DSRIP?

DSRIP is short for Delivery System Reform Incentive Payment

- In April 2014, the NYS finalized an agreement with the Federal government to allow NYS to reinvest $8 billion of the $17.1 billion in savings generated through Medicaid Redesign Team ("MRT") reforms.

- DSRIP will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital admissions over five (5) years.

- Up to $6.42 billion dollars are allocated to the DSRIP program with payouts based upon achieving predefined results in system transformation, clinical management and population health.
Who are the DSRIP Key Players?

- **PPS** – Entities that are responsible for creating and implementing a DSRIP project are called “Performing Provider Systems” ("PPS"). Performing Provider Systems are providers that form partnerships and collaborate in a DSRIP Project Plan. PPS include both major public hospitals and safety net providers, with a designated lead provider for the group, known as a PPS Lead. Safety net partners can include an array of providers: hospitals, health homes, skilled nursing facilities, clinics & Federally Qualified Health Centers ("FQHCs), behavioral health providers, community based organizations and others.

- **PPS Lead** – The PPS Lead is a safety net provider that serves as the convener of the performing provider system. The PPS Lead is responsible for:
  
  - Overseeing the administration and operation of the PPS in accordance with the PPS governance structure;
  - Serving as the recipient of funds from NYS; and
  - Distributing funds to the PPS partners in accordance with participation agreements and agreed-upon funds flow plans.

- **PPS Partner** - The PPS Partner is a provider or other entity that has entered into a participation agreement with the PPS Lead to perform certain services and collaborate with a PPS in connection with the DSRIP program and/or one or more DSRIP projects.
Who are the DSRIP Key Players?

- **PPS Compliance Officer** – The PPS Compliance Officer is a PPS Lead employee who has been given responsibility for the day-to-day operation of the PPS’s compliance program.

- **Compliance Liaison** – The Compliance Liaison is an employee of a PPS Partner who has been given responsibility for carrying out the day-to-day operations of the Partner’s DSRIP compliance program, including working with the PPS Lead Compliance Officer.

- **NYS Office of the Medicaid Inspector General (“OMIG”)** – The Office of the Medicaid Inspector General (“OMIG”) is an independent entity created within the NYS Department of Health (“SDOH”) to promote and protect the integrity of the Medicaid program in NYS. OMIG functions to enhance the integrity of the NYS Medicaid program by: (i) preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program; (ii) recovering improperly expended Medicaid funds; and (iii) promoting high quality of patient care.

- **DSRIP Independent Assessor** – The DSRIP Independent Assessor is a vendor contracted by SDOH. The DSRIP Independent Assessor is responsible for conducting the ongoing monitoring of performance and reporting deliverables for the duration of the DSRIP program.
Overview of OneCity Health

- OneCity Health is comprised of (i) operating hubs throughout NYC; (ii) a committee-based governance structure; and (iii) a central services organization providing operational management, called OneCity Health Services.

- OneCity Health is comprised of hundreds of healthcare providers, community-based organizations, and health systems and is the largest PPS in New York City ("NYC"). OneCity Health envisions the establishment of a welcoming, accessible, and integrated health delivery system that encourages, supports, strengthens, and protects a state of wellness and healthy living for all.

- OneCity Health is required to perform a community assessment of need, identify DSRIP strategies that are most consistent with addressing that need, develop a Project Plan incorporating those strategies, implement this Project Plan and monitor milestones and metrics to ensure the implementation is successful.

- All OneCity Health Partners sign a DSRIP Master Services Agreement ("MSA") with NYC Health + Hospitals as the PPS Lead, and HHC Assistance Corporation d/b/a OneCity Health Services, as the central services organization. The MSA defines the foundational roles and responsibilities of each entity.
Section 2

Overview of Compliance and the NYC Health + Hospitals’ Corporate Compliance & Ethics Program
Compliance is an organizational culture that fosters the prevention, identification, and remediation of conduct that fails to comply with applicable law and/or an organization’s own ethical and business standards of conduct.

Ethics is doing the right thing and includes:

- Acting fairly and honestly;
- Complying with standards of conduct;
- Complying with all applicable legal requirements including fraud, waste, and abuse laws;
- Following industry practices that are lawful, fair, and non-deceptive in nature;
- Adherence by professionals to applicable ethical standards of conduct dictated by their respective professional organizations;
- Reporting compliance violations; and
- Enforcing disciplinary policies.
NYC Health + Hospitals' Corporate Compliance & Ethics Program focuses on:

- The prevention, detection, and correction of fraud, waste and abuse;
- Information governance;
- Risk identification, assessment, and prioritization;
- Corporate governance; and
- Establishing and monitoring internal controls.

NYC Health + Hospitals Chief Corporate Compliance Officer ("CCO") is Catherine Patsos, Esq.

The CCO is the chief officer in charge of ensuring that NYC Health + Hospitals complies with all applicable laws and its own standards of ethical conduct, directing compliance activities across the System and general oversight of the OCC.
Overview of Compliance

NYS regulations require all providers that bill the Medicaid program $500,000 or more annually to establish an effective compliance program in order to be eligible to order, bill or receive Medicaid payments for care, services, or supplies. Effective compliance programs must have:

- Written policies and procedures that describe compliance expectations as embodied in a code of conduct;
- Designation of a Compliance Officer;
- Training and education programs;
- Direct communication lines which allow for the anonymous and confidential reporting of compliance issues;
- Disciplinary policies to encourage good faith participation in the compliance program;
- A system to routinely identify and address vulnerabilities and risks;
- A system to respond to compliance issues as they are raised and/or identified; and
- A policy that prohibits intimidation and/or retaliation.

Not all Partners are required to have their own compliance programs under NYS law, but all must comply with the requirements of their PPS Lead’s compliance programs. Some Partners that were not previously required to have compliance programs may become required to do so, by virtue of receipt of DSRIP payments that result in their meeting the $500,000 threshold.
Effective DSRIP compliance programs that focus on the compliance risks and concerns within DSRIP must include:

1. Policies and procedures that describe compliance expectations specifically related to the compliance issues involving DSRIP funds.

2. Appointing a compliance officer who must be an employee of the PPS lead and shall periodically report directly to the governing body on activities of the compliance program.

3. Training and education (on compliance issues and expectations) of all its affected employees, executives governing body members, and "persons associated with the provider" which include preforming providers within the PPS Network and those who are eligible to receive DSRIP funds.

4. Establishing a process of reporting compliance issues to its Compliance Officer which must include an anonymous and confidential method of reporting.

5. Policies and procedures that include disciplinary policies and procedures to encourage good faith participation in the compliance program by all affected individuals.
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6. Development and implementation of a system for routine identification of compliance risk areas.

7. Development of a policy of non-intimidation and non-retaliation for good faith participation in the compliance program. PPS Leads will also need to work with their Partners to support compliance with this requirement.

8. Development of a system for responding to compliance issues that are raised. A PPS Lead should consider its own willful misuse of DSRIP funds, or false statements made by a PPS Lead or its network providers to obtain DSRIP funds, as examples of compliance issues. The PPS Lead’s system must also include a method for prompt corrective action and refunding overpayments.
In September 2015, OMIG issued DSRIP Compliance Guidelines, which contain the following language:

- “PPS Leads... must...take all reasonable steps to ensure that Medicaid funds distributed as part of the DSRIP program are not connected with fraud, waste or abuse. It is reasonable for a PPS Lead to consider its [PPS Partners’] program integrity systems when [doing so].”

- “PPS Leads can focus their compliance program risk assessments on those risks specifically associated with the current phase of the DSRIP program and payments made pursuant to it.”

- “PPS Leads are not responsible for network providers’ individual compliance programs that may be required in connection with their status as a serving provider. Likewise PPS Leads cannot be responsible for how network providers use their respective DSRIP distributions, but PPS Leads must have adequate processes in place...to be able to identify when network providers obtain DSRIP distributions in a way that is inconsistent with approved DSRIP Project Plans.”

OMIG considers “overpayments” to include DSRIP payments that are inappropriately issued based upon data from DOH and are expected to be recovered through DOH’s established protocols.
DSRIP Compliance under NYC Health + Hospitals

- The NYC Health + Hospitals’ Office of Corporate Compliance assumes OneCity Health DSRIP-related compliance responsibilities. Partners must have compliance programs as required by NYS or NYC Health + Hospitals in connection with the DSRIP Program.

- Partners must certify to OneCity Health and the OCC to confirm its full performance of its compliance obligations. NYC Health + Hospitals will rely upon such certifications in fulfilling their own compliance obligations.

- The OCC will routinely distribute, to Partners, information regarding the Deficit Reduction Act of 2005, which details NYC Health + Hospitals’ policies prohibiting fraud, waste, and abuse and relevant Federal and NYS laws on false claims and statements and whistleblower protections from retaliation.

- OneCity Health workforce members as well as Partners are required to report DSRIP-related compliance concerns to the OCC. The OCC directly investigates DSRIP compliance issues or delegates that duty to the involved Partner, who would then be responsible for reporting results of their investigation back to the OCC.

- OneCity Health and the OCC will conduct periodic DSRIP specific risk assessments and identified issues particular to OneCity Health.
OneCity Health Partners must comply with NYC Health + Hospitals Principles of Professional Conduct ("POPC").

The POPC sets forth the expectation that all covered parties will conduct business in a lawful and ethical manner and provides guidance on the prohibitions against improper billing, the submission of improper claims including the misuse of DSRIP funds, the making of false statements, illegal kickbacks, conflicts of interest, the improper disclosure of confidential patient information and other compliance topics.

The POPC also applies to all workforce members of NYC Health + Hospitals including but not limited to:

- All employees, volunteers, students and affiliates;
- Members of the NYC Health + Hospitals Board of Directors;
- Directors of NYC Health + Hospitals wholly owned subsidiaries;
- Any individual whose work duties and functions are performed on behalf of and under the control of the System whether or not they are paid by the System.
POPC and Partner Responsibilities

The following are a few examples of actions that would be considered violations of the POPC and unprofessional or illegal conduct:

- Violating the Federal or NYS laws on fraud, waste and abuse;
- Hiring or contracting with persons or entities excluded from participation in a Federal health care program;
- Failing to promptly report and refund, as required by law, any overpayment;
- Engaging in conflicts of interest and/or violations of New York or NYC Health + Hospitals Code of Ethics;
- Conduct that leads to workplace safety violations or produces a hazardous environment;
- Improperly using confidential or proprietary information;
- Falsely or inaccurately documenting in a medical record;
- Engaging in workplace misconduct (e.g., conduct discriminatory in nature, or amounts to sexual harassment, or constitutes intimidation as well as any act or threat of violence); and
- Failing to provide care because of a patient’s inability to pay for services.
Section 3

Fraud, Waste & Abuse & Relevant Federal & NYS Laws
**Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person.

Fraud consists of, among other things, intentionally making false statements or misrepresentations or submitting false information in order to receive money or benefits to which one is otherwise not entitled.

**Waste** includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to a Federal health care program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

**Abuse** includes actions that may, directly or indirectly, result in unnecessary costs to a Federal health care program and involves payments for items or services when there is no legal entitlement to that payment. However, unlike fraud, the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.
Fraud, Waste and Abuse

Examples of **Fraud** include:

- Knowingly billing for services or prescriptions not furnished or supplies not provided;
- Knowingly altering (or falsifying) claim forms, medical records or receipts to receive a higher payment;
- Knowingly soliciting, receiving, offering, and/or paying for referrals related to a Federal health care program; and
- Knowingly billing for appointments patients failed to keep.

Examples of **Waste** include:

- Conducting excessive office visits or writing excessive prescriptions;
- Prescribing more medications than necessary for the treatment of a condition; and
- Ordering excessive laboratory tests or exams.

Examples of **Abuse** include:

- Billing for services that were not medically necessary;
- Charging excessively for services and supplies; and
- Billing for brand name drugs while generic drugs are available.
Federal False Claims Act ("FCA")

The FCA makes it illegal to *knowingly* (i.e. with actual knowledge as well as acting in deliberate ignorance or with reckless disregard of the truth), among other things:

- Conceal or improperly avoid or decrease obligations to pay the government;
- Make or use a false record or statement supporting a false claim;
- Present a false claim for payment or approval; or
- Conspire to violate the FCA.

Individuals can bring legal actions ("*qui tam*" actions) on behalf of the Federal government for false claims, and are protected from retaliation for doing so. Penalties under the FCA include but are not limited to:

- Up to $21,563 for each false claim;
- Plus three times the amount of damages; and
- Any costs the government incurs when an action is brought to recover any such penalty or damages.
In addition to civil liabilities which may be imposed for violations of the FCA, the Criminal Health Care Fraud Statute, in relevant part, makes it a Federal crime to knowingly and willfully execute or attempt to execute, a scheme or artifice to:

- “Defraud any health care benefit program”; or
- “Obtain by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the control of, any health care benefit program.”

Penalties include fines, imprisonment, or both.
Physician Self-Referral Law ("Stark Law")

The Physician Self-Referral Law, often called the Stark Law, prohibits (with some exceptions) a physician from making a referral for certain designated health services payable by Medicare or Medicaid to an entity in which the physician (or his/her immediate family member) has a financial relationship.

Financial relationships can be defined as those in which there is:

- An ownership/investment interest; or
- A compensation arrangement.

The Stark Law also prohibits the provider of the designated health service from submitting a claim for payment for a designated health service furnished pursuant to a prohibited referral.
Anti-kickback Statute ("AKS")

The AKS in relevant part, makes it a crime for anyone to knowingly and willfully solicit, offer, pay or receive any remuneration:

- In return for referring an individual to a person for the furnishing or arranging of any item or service for which payment may be made in whole or in part under a Federal health care program; or

- In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program.

If an arrangement satisfies a regulatory safe harbor, it is not treated as a violation.

Violators face criminal penalties and fines for acts that impact a Federal health care program’s reimbursable services under this law.
Civil Monetary Penalties Law

This Federal law allows the government to seek certain civil penalties for violations involving fraud, waste and abuse. The U.S. Department of Health and Human Services Office of Inspector General ("OIG") may impose civil penalties for a number of reasons, including but not limited to:

- Knowledge of an overpayment and failing to report and return it;
- Making false claims;
- Paying to influence referrals;
- Arranging for services or items furnished by an individual or entity excluded from a Federal health care program;
- Submitting a claim for services or items furnished by an individual or entity while excluded from a Federal health care program; or
- Failing to grant OIG timely access to records.

Penalties range from $5,000-$50,000 depending upon the type of violation and may vary based on the particulars of each violation (e.g. the number of false claims or the number of each prohibited relationship).
The NYS False Claims Act has similar provisions found in the FCA and makes it illegal to *knowingly*, among other things:

- Present or cause to be presented a false or fraudulent claim for payment or approval to NYS or a local government;
- Make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim to NYS or a local government;
- Conceal or avoid paying funds to NYS or a local government; or
- Conspire to commit a violation of various provisions of the NYS False Claims Act.
NYS Social Services Law and NYS Penal Law prohibit individuals from:

- Knowingly obtaining or making an attempt to obtain (or continue to receive) public assistance by way of making false statements or by means of other fraudulent acts or actions;
- Knowingly submitting a false claim or false information for the purpose of defrauding the Medicaid program or to receive a higher Medicaid compensation than entitled to under the law for services rendered; and
- Falsifying business records and offering a false instrument for filing.

Penalties for violations of these laws include but are not limited to:

- $6,000-$12,000 dollars per claim;
- Three times the amount of the damages which NYS or a local government sustains because of the act of that person;
- Being charged with a Class A misdemeanor; and
- Further criminal prosecution for larceny.
Exclusion Authority Overview

Individuals and entities that have engaged in fraud, abuse or misconduct (including quality of care issues), can be excluded from participation in Federal health care programs.

- Excluded individuals and entities can include providers, employees, and Board Members.

- Exclusion periods can vary in length from months to years and can also be permanent.

Individuals or entities cannot be paid either directly or indirectly by a Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity.

NYC Health + Hospitals has an obligation to ensure that its workforce members are not among those who are excluded. NYC Health + Hospitals monitors Federal and state government lists that include the names of excluded individuals and entities.

Partners should perform monthly exclusion screening of associated Individuals or entities. If an excluded party is identified, the OCC must be notified.
Section 4

Reporting Compliance Issues & Policy on Non-Retaliation
Responsibilities to Report

OneCity Health is required to report to the OCC, violations of policies, the POPC, and any applicable laws, rules and regulations.

Failure to:

- Report a violation;
- Participate in or cooperate with an investigation;
- Be truthful with investigators;
- Preserve documentation and/or records relevant to ongoing investigations; or
- Participating in, encouraging or permitting non-compliant behavior;

will result in disciplinary action and/or sanction which includes written warnings, suspension and/or termination of employment, contractor or other affiliation with NYC Health + Hospitals.
Protection Against Retaliation

NYC Health + Hospitals strictly prohibits intimidation or retaliation, in any form, against any individual who in good faith reports compliance violations and participates in the compliance program.

What is Retaliation?

Retaliation is a negative action taken by any person or entity against an individual as a result of an individual performing a protected activity (e.g. good faith reporting of or participation in the investigation of compliance issues).

Actions include unwarranted discharges, demotions, suspensions, threats, harassment, or discrimination of the individual by any person or the entity because of protected activity conducted.
How do I report compliance issues or concerns?

Office of Corporate Compliance
Call, write, email or visit the OCC:
160 Water Street, Suite 1129,
New York, NY 10038
(646) 458-5632
compliance@nychhc.org

Compliance Helpline
NYC Health + Hospitals/OneCity Health
DSRIP Compliance Helpline
1-844-805-0105

PPS Partner Compliance Liaison
Contact your DSRIP Compliance Liaison.

*All reports made will be held confidential to the extent possible under the law.*
How can you support Compliance?

- Lead by example;
- Support the efforts of the OCC;
- Assist with audits, reviews, and investigations;
- Report issues or concerns and ask questions; and
- Take appropriate action when needed.

If you have any questions about the content, topics, information or situations posed in this training, please contact the OCC at (646) 458-5632.