NYC HEALTH + HOSPITALS

AUDIT COMMITTEE
MEETING AGENDA

February 7, 2018

11:00 A.M.

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

CALL TO ORDER — Ms. Emily A. Youssouf

- Adoption of Minutes January 11, 2018 — Ms. Emily A. Youssouf

ACTION ITEMS

- Resolution — Mr. PV Anantharam

  Amending the resolution of the Board of Directors (the "Board") adopted in April 2014 authorizing the New York City Health + Hospitals (the "System") to execute an agreement with KPMG LLP ("KPMG") to perform auditing services and other directly related services for an amount not to exceed $3,487,000 plus a 10% contingency reserve of $340,000 for a total not-to-exceed amount of $3,827,000 with such amendment adding $300,000 to the funding authorized for the contract to accommodate work required to have been performed in connection with the Medicaid Administration grant in order to increase the not to exceed amount of the contract with KPMG to $4,127,000.

INFORMATION ITEMS

- Audits Update — Mr. Chris A. Telano
- Compliance Update — Ms. Catherine Patsos

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

NYC HEALTH+ HOSPITALS

MINUTES

AUDIT COMMITTEE

MEETING DATE: January 11, 2018
TIME: 10:30 A.M.

COMMITTEE MEMBERS
Emily Youssouf, Committee Chair
Mitchell Katz, MD
Josephine Bolus, RN
Gordon J. Campbell
Helen Arteaga Landaverde, MPH

STAFF ATTENDEES
Salvatore J. Russo, General Counsel, Legal Affairs
Colicia Hercules, Chief of Staff, Chairman's Office
PV Anantharam, Senior Vice President/Corporate Chief Financial Officer
Jay Weinman, Corporate Comptroller
Wayne A. McNulty, Corporate Compliance Officer/Senior Assistant Vice President
Catherine Patsos, Deputy Compliance Officer
Christopher A. Telano, Chief Internal Auditor/Senior Assistant Vice President
Devon Wilson, Senior Director, Office of Internal Audits
Chalice Piña. Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Jean Saint-Preux, Staff Auditor II
John Cuda, Chief Financial Officer, MetroPlus
Jose Santiago, Controller, MetroPlus
Elsa Cosme, Chief Financial Officer, H + H/Gotham
Robert Malone, Chief Financial Officer, H + H/Queens
Anthony Saul, Chief Financial Officer, H + H/Kings
Kiho Park, Chief Financial Officer, H + H/Coney Island

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

JANUARY 11, 2018
AUDIT COMMITTEE MEETING
MINUTES

An Audit Committee meeting was held on Thursday, January 11, 2018.

The meeting of the Audit Committee was called to order at 10:36 A.M. by Ms. Emily Youssouf, Audit Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee held on December 7, 2017. The minutes were unanimously adopted by the Committee.

Ms. Youssouf said that today the main purpose of this meeting is for a review of the management letter by KPMG so I am going to turn it over.

Ms. Maria Tiso, KPMG Engagement Partner, introduced the audit team members consisting of Mike Breen, Engagement Partner; Jim Martell, Partner and Camille Fremont, Engagement Senior Manager.

Ms. Tiso stated that we are here today to present our management letter. If you recall, we presented the results of our audit in a meeting at the end of October. In that meeting we discussed overall that any of the management letter findings that we identified were not material weaknesses or significant deficiencies. We were prepared to come to a meeting in December and that was delayed to January. So I would like to start with our opinion, and as I mentioned, none of these comments in this letter warrant a significant deficiency or material weaknesses. Again, these are operational improvement comments to improve the internal controls over financial reporting of the system.

We also addressed prior year comments, the ones that were remediated and we were comfortable with those comments, and then we also have some industry comments that we have been including in other larger health system management letters to alert the audit committee and the board of some of the risks and trends that are out there, Mr. Martell will touch upon some of those. Before I turn it over to Ms. Fremont to go through the letter, this year was, again, a complex audit. There were, again, new GASB standards. There were three that needed to be adopted by the management team. Adopting three standards in one year is very complex for the financial reporting team.

As we discussed last year, liquidity, became a significant area for the financial reporting and for us to navigate through during the year. Obviously we look at significant trends and there were issues with the DISH payments and the UPL payments. It was really always touch and go throughout the audit, so thank you Mr. Anantharam and Mr. Weinman and his team for your cooperation during the audit. Next is the matrix of observations, in the past we have the facilities listed what the management letter refers to. This year, these comments relate to the System, more around financial.

Ms. Fremont stated that we are going to start with the financial reporting and the alignment of finance resources, and what our recommendations would be, and management is in the process of implementing some of these recommendations, by going through and assessing the needs of the organization and their available resources and ensuring that the department is best structured to suit their needs. Also, throughout the preparation of the financial statements, there should be a formal review that is done at a level of precision that could identify potential issues prior to submission for us to review. And management does use a responsibilities checklist as they are going through the process.

Our recommendation is to continue to update that checklist to make sure it's the most up-to-date and covers all of your required disclosures. And as a leading practice, during the compilation of the financial statements, you should prepare financial statement footnote disclosure checklists which will serve as a memory jogger to you to ensure that you have all the required disclosures.

The next area we will focus on is patient accounts receivable. That is one of your more complex areas that requires judgment within the financial statements, and management has a process that they continue to refine to update their methodology, and the review is done over the methodology. Some of the things we noted and would suggest to management to consider is looking at the potential impact of aging your in-house accounts, any individually significant balances, and the most recent collection experience that you are getting from this orientation accounting system, as well as ensuring that as you are doing this process, could you potentially use a data and analytics tool to help you comb through the large amount of data more easily.

Within your analysis, you have a receivable for MetroPlus. We want to ensure that that receivable correlates to the liability that you have so that it makes sense globally. Within your patient accounts receivable, there will always be credit balances, and you have a large credit balance population, and management should just ensure that they are doing a formal review to ensure that those credit balances truly are over contractual allowances and not potentially refunds due back to individual payers or patients. Additionally, what we saw during our test work is that there were some, in one of our samples, a large account balance, over $150,000 for a patient balance, and that is something that management should be reviewing within their patient AR to see if any of that relates to mis-postings, which was the case in this scenario, so that your valuation isn't thrown off by that.

Additionally, just to continue to monitor your unapplied cash balances. So that is cash that has come in the door for you but has not yet been applied against the patient accounts receivable.

Ms. Youssouf asked you said that you found one patient account that was $150,000? To which Ms. Fremont answered yes.

Ms. Youssouf commented that given the number of patients we have, I don’t know it there is any way we can do that.

Mr. Weinman answered that it is practically impossible to find these things because we do a very high level analysis. We plan on purchasing the software recommended by KPMG that will allow us to do the analytics, essentially an audit tool, and if we set the parameters right, we will be able to extract out those cases that we deem to be applied. We are in the process of procuring the software, but until then it really isn’t plausible.

Mr. Anantharam added that this has happened in the past where we've got multiple accounts of an individual and then we get a payment from the individual. They were applied to one account as opposed to the individual places. So certain accounts in that place get reflected incorrectly, if you will. It's all for the same patient but for different instances. I do believe that when we have EPIC in place across the system things will be more aligned.

Ms. Tiso commented that if you look through some of our industry comments, we do make reference to data analytics. This Idea tool is really a data and analytics tool, it refines the way management can analyze their data and find these type of variances in trends in their population. It is a great thing that they are purchasing that tool.

Mr. Breen added that it's a tool we use during the audit when you're dealing with large volumes of data and you're trying to even identify significant accounts that you want to look at separately, these tools are great.

Mrs. Bolus asked how many of these type of patients do you estimate that we have?

Mr. Weinman answered that it would be hard for us to estimate. The one thing I could say is the overall balances that we value to account for all high balances, low balances, but, you know, specifically we don't identify the high balances. The only way to tell is when we purchase the software where we can kind of strip those cases out. But I imagine it is a very small amount.

Mrs. Bolus asked that do you think there will be more the basis who are uninsured, someone will have some semblance of assurance?

Mr. Weinman answered when we institute the implementation of the software and we integrate it within our analysis, we will be able to tell you.

Mr. Anantharam asked what the timeline is:

Mr. Weinman responded that we'll be starting to use it for the next fiscal year, this coming fiscal year 2018.

Mrs. Bolus asked can you give us a ballpark figure of what this software is going to cost?

Mr. Weinman responded about $3,000.00.

Mrs. Bolus said that is all?

Ms. Tiso added that it is just getting somebody trained on how to use the software. We have some of our team members that are very savvy in using the software, so we have offered to have them help Mr. Weinman and his team navigate through the software once it is installed.

Ms. Fremont continued with third-party estimates. That is another large estimate within your financial statements. Although there are discussions between Mr. Weinman's department and your reimbursement department, you need to formally evidence that review and ensure that any significant assumptions within the calculations, the support is being obtained by the comptroller's office to make sure it's appropriate.

The next couple of comments we will talk about relate to MetroPlus. We talked about this before, but the first area that we will highlight upon is the fact that during our test work we saw claims where the underlying contractual agreements rate was not updated appropriately within the system. We would suggest to management that in the process of implementing our processes and controls to identify the appropriate contract rates in the system and ensure the billing system is billing appropriately. Additionally, we saw a certain review of account analysis whereby a certain initial analysis either did not utilize the most recent information available related to the stop loss receivable or upon review of the calculation in the current year you realized that there needed to be an adjustment to prior year balances for your paper performance liability. We just suggest that management continue to refine and enhance their policy and procedures and ensure that all balances reported within the financial statements are appropriate and supported.

We continue to suggest to management, and due to system limitations they are unable to implement at the current time, but you should have a detailed accounts payable sub-ledger that you can reconcile into the accounts payable per the general ledger. Additionally, we would suggest that for your capital assets that there's controls put in place and enhancements to education of the staff to ensure that they're appropriately accounted for at the time of acquisition. So what we saw is, rather than expensing

the fixed asset, it had gone to capital contribution, and that was not the appropriate accounting for it at the time.

Ms. Youssouf asked do you want to make a comment because we have spent a lot of time on this, that it might be good to have it on the record?

Mr. Weinman answered that we have spent a lot of time on fixed assets. There was instance where the asset was recorded. It was construction in progress and so it was a depreciable asset but the liability had not been setup, and so that was a training issue. Part of the entry was done and the other side of the entry was not done. In this audit work that KPMG did, they identified this because it was about $26 million. It was identified during the audit and it is reflected in the financial statements. Going forward, the remediation that we have is that all entries now go through a secondary review. I have reorganized my department to have basically a chief of accountants review all of the fixed assets entries to ensure that everything is recorded. It got past us and thank God it got picked up by the audit.

Ms. Youssouf asked do you want to take a minute and just describe what MetroPlus is doing for the recommendation.

Mr. John Cuda introduced himself as Chief Financial Officer for MetroPlus and reported that since the audit finding, MetroPlus increased its review of contract setup, which expanded further into older contracts. This happened to be an older incident that happened back in '08. As part of our review, we have a normal claims validation audit that we go through. We have taken samples of those audits and applied a sampling of contracts to go back to the original set up of the contract in the system. We are validating and verifying that the contract terms are set up properly in the system. We have done that with our ongoing four percent claims sample of auto-adjudicated claims. We have also done our manually adjudicated claims, and we have done a sample of our 300 claims sample for our auto-adjudicated claims. So we're hitting both sides of those. That's out of the claims payment. On top of that, on the provider setup, we are sampling five standard contract setups, five nonstandard contract setups semimonthly to continually go back into the history and verify those contracts are setup correctly.

The immediate mitigation to this after we found it was that we took several different types of contracts, like DME, specialists, radiology, a couple of different cuts and we did five random contracts out of those to immediately do a testing, and we found that no other contracts are setup incorrectly.

Ms. Youssouf asked if KPMG has reviewed what they are doing and you were satisfied that the protocol setup was appropriate?

Mr. Breen answered yes, we went through the enhanced controls and procedures that management was going through during the System audit. At the System level, as you know from this committee, we said we were comfortable, but there is a standalone 12-31 year-end audit, which is at the standalone MetroPlus level. We said that that will be the next test, we are meeting with Mr. Cuda this afternoon to start discussing our procedures for that audit.

Mr. Campbell asked are you comfortable with what management has put in place in terms of the new protocol going forward?

Mr. Breen responded yes, we are comfortable with the design of the procedures.

Mr. Campbell stated that what I meant and are you going to be testing it?

Mr. Breen answered exactly, the true test is going to be when we test it for the year-end audit.

Ms. Fremont continued with the presentation and said that in terms of grants receivable, that sub-ledger should be reconciled to the general ledger. Throughout the course of the audit, we identified a discrepancy between the reconciliation.

The next area we want to touch upon is liquidity, and, as Ms. Tiso mentioned before, we did spend a lot of time assessing liquidity given the changes in the environment. What we noticed was that management is going to continue to have challenges to fulfill your mission, and as they go through those challenges, they need to ensure that their focus on initiatives that can help you contain costs and work with the city in terms of the transformation plan or the vision 2020 and take all necessary action to ensure your funding remains at the levels that allow you to do what you need to do.

Ms. Tiso added that we envision that liquidity is going to continue to be a significant risk to the system going forward. And I think one of the things that concern us is the DISH funding, the UPL funding, any reimbursement changes that are going to happen, going forward.

Ms Youssouf added that it concerns us all.

Ms. Freement reported that we are going to focus now a little bit on some of your information technology comments, and these are comments that have existed in the past, and the first one relates to your password configuration settings. We suggest that you conform those password settings to meet industry leading practices and update your policies to reflect those requirements. Additionally, we noted, during our test work, that there were terminated users that were not timely removed from the system. So continue to focus on the need to remove access once it's no longer necessary. And within that access is looking through and doing a periodic review of system access to ensure that current access is appropriate for the level of needs that the user has.

Ms. Youssouf commented that this is one thing that, now we even have a new head of information technology, and I know he is aware of this issue and it is something we have been attempting to address, and I'm sure we will get it addressed.

Mr. Anantharam added that with the addition of new technology along the lines of PeopleSoft, ERP, EPIC and all of those things will bring a lot more standard across the board.

Ms. Fremont continued and said that we will briefly talk about the tax comment that we have related to Treasury Regulation 501-R. There are certain specific requirements under this regulation. We recommend that management updates its invoices or bills to the patient so that it clearly addresses the financial accounting policy where it can be found online. It is mentioned in the invoices, but there was not a link to the actual policy online and that is a requirement.

Additionally, for H + H's Options policy, which is your financial assistance policy, you need to make sure it clearly spells out the method that you go about to determine the amounts generally billed to patients under that policy.

Ms. Youssouf asked make it standard that is put on each piece of paper on each bill?

Ms. Fremont responded that the link to the policy has to be on each bill. Then your method that you go through to identify how you are billing them needs to be written within the policy.

Ms. Youssouf asked who does that come under?

Mr. Anantharam said that it could mean that we will have to incorporate those changes into the bills that we send to everybody. It doesn't reflect any incorrect billing of any of these patients. What is being suggested is that you make it more evident to individuals on what the policy is and give them access to the locations that they can go and evaluate that bill.

Ms. Youssouf asked if it's also a Treasury Regulation, so we need to do it and who does that come under?

Mr. Anantharam responded that it will be the finance office.

Ms. Youssouf asked if that is in the process of being done?

Mr. Weinman answered yes.

Ms. Fremont reported that we have gone through and identified those prior year comments that has been addressed during the course of this current fiscal year. The first comment that we had related to MetroPlus and the communication between their finance department and the comptroller's finance department, and there have been processes put in place so that communication is ongoing, and we noticed that there were no issues identified during that process. And what the comptroller's office and MetroPlus is doing is ensuring any related party transaction balances are agreed to between the two entities, so there is no differences within the financials.

Additionally, the fixed asset depreciation comment which is related to certain facility comments has been addressed. We did not see that in our current work.

Then there were certain tax comments from last year that management has addressed. In relation to incorporating certain information in your federal form 990 filing, that has been done, as well as ensuring that Gotham is now up-to-date on its tax filings.

Ms. Tiso stated that that concludes the entity specific comments, we are going to move to the industry comments.

Ms. Landaverde asked if the tax ID affects our Gotham reimbursement.

Mr. Anantharam responded no, the transition from all the management changes that happened over the last two to three years resulted in a gap in following up on all the filings of the 90s and they have since filed it.

Mr. Martell reported that the last four or five pages really relate to observations that we see in the industry. And if you take a step back, what's a management letter? A management letter is a criticism of management in their internal controls and processes. Not a nice letter, but required by our standards. However, when you think about the criticism letters, Ms. Tiso said that the items identified here are not a material weakness and not a significant deficiency. These are improvements that can be enhanced for overall reporting and aspects associated with that.

As you go through the industry comments and think about where we are in terms of an organization, you are changing, you are going through EPIC, PeopleSoft. There is a lot of IT changes going on. There is a lot of organizational changes going on. Mr. Weinman has informed us that you are taking the individual facilities and bringing a lot of those individuals into the corporate office. You are a huge system; $7-$8 billion. You were fragmented in the past from a reporting perspective.

Bringing them in will do two of three things, at least two of three things. You have the strongest skill set of the individuals at corporate by breaking out the general accounting, for lack of a better word, moving the day-to-day operations and the financial reporting. A lot of these GASB issues and things of that nature will be addressed. And you can start looking at things such as the valuation of receivables with this new tool Idea. So there will be a lot more monitoring. All of that is changes that are going on within the system. Put on the top of that decreased revenue streams, you talk about the DSH, talk about cyber security, which is in here, you talk about Medicare assets and CHIP. I read this morning that there are some consultants, good, bad or indifferent, think MA, Medicare Advantage, is going to increase by 70 percent, which will effect MetroPlus business and so forth.

Right now, roughly 30 percent are in Medicare Advantage. They think with the next 18 months not KPMG, these are things that I am just reading are going to go 70 percent, double, in a little more than 18 months. When you take a look at the industry comments, it's more to promote discussion. What are we, at H + H, doing to deal with our environmental exposures, our issues that we have to deal with? And

as we deal with risk assessment, and as Ms. Tiso and her team deal with risk assessment, that's why the focus is getting more and more on the corporate world, on the corporate organization. The risk of reporting financial presentation is at corporate. We still do all the detailed analysis associated with internal control testing out at the sites, but the focus has become corporate because that's where all the major risk assessment or risk issues are being identified.

The last thing I am going to do as more of a sounding board amongst the Board and if there are any observations that you want to further talk about, Ms. Tiso can bring the right people. It is informational and where the industry is, as opposed to well, H + H is not doing this. So that is my little 5-minute public announcement speech.

Ms. Youssouf asked are there any trends that is best practice that we are not doing that should be doing?

Mr. Martell responded that you take a step back and you think about healthcare in general. Over the last 5 or 10 years, everybody's been talking about the Continuum, managing the patient. Let's get them out of the hospital. I want to make sure we service them in the community and so forth. So obviously population health is a big, big thing. That's part of the whole DSRIP program. I have clients that really believe by 2020 60 percent of their business will be on the ambulatory care side as opposed to the bricks and mortars on the inpatient side. I think that's a trend. I think it will go there. Our facilities indirectly end up being the physician, the emergency rooms, and the ED departments become the physician of the patients. How do you educate the community to go to the urgent care centers or the ambulatory care centers. There is an education process, that trend has to continue. So I think the whole aspect of the delivery of medicine as to which inpatient, outpatient, ambulatory care and so forth is going to continue to focus on population health, deal with managed care, deal with risk. It's going to become a lot more prevalent, even though perhaps you would sit back and say Trump's not involved with that right now. He thinks it's wrong. I do believe that it will be there going forward. So Ms. Youssouf, the answer is the trends are going to the ambulatory care side and you got to continue to move there, big time. And then what do you do with the infrastructure, what do you do with these huge facilities that you have.

Ms. Youssouf stated that I appreciate that – I do have one question, on some of the large systems that you cover, are they consolidating like we are?

Mr. Martell answered absolutely, from a reporting perspective, I will tell you they are getting very aggressive in acquiring the surrounding, the suburban hospitals and so forth and trying to get, obviously, the inflow of the tertiary and quaternary type procedures down here. But consolidation is occurring, do more with less. The reality that it comes down to is in today's environment with everybody overlooking from a financial reporting, from a liquidity, from a clinical and all that, there is a lot more work that has to be done. And when you do consolidate, you identify people with skill sets that are able to take on additional workloads or you are able to evaluate how I change the process we have in place to get the point of these types of reviews that have been completed.

Ms. Youssouf asked if there any comments, questions from the Board?

Mrs. Bolus stated that I agree with a lot what you say, but the problem comes, money. We can't seem to go into the neighborhoods and zoom in and pick up a storefront and convert so that we are in the community. That is a lot of money and we just don't have that. And our problem comes, we thought about putting a bus out there saying we will bus you into Kings County and back home so you are back in your neighborhood. That has not worked, we need new ideas because we need to be in the community. They have the pleasure of saying if you walk in, you will be seen. If you call me, I will make an

appointment for you tomorrow. Because they do not have the backflow of charts that we have. They create a new chart when you come in the door and you are seen right away and so they have a whole new perspective. The person meets a brand new doctor, a brand new nurse practitioner, brand new physician assistant, and they are satisfied with that. We just don't have the opportunity to do that, we really don't, and we don't pay what they are getting paid. And our problem is how do we get people to come and work for us. That is the big problem, not so much what we need, we need those things and we know we need those things, but how do we acquire those things, because we need the money to do so and we just don't have it. So come up with some ideas about how we can get some.

Mr. Martell answered I will. I mean, one item that just comes -- just pops in the head and it relates to the whole DSRIP program and so forth. You have your own PPS's partnering with all of these, and you are starting to do that. When I sit here and say to other clients, the one thing I constantly say is how do you identify alternate revenue streams or reduce operating. You can squeeze expenses so much, but eventually you have to increase the revenue stream, and how does one go about doing that. The only way you can come up with some of those ideas is a senior management team siting in a room like this and throwing ideas up in the ceiling, and as stupid as some of these recommendations may be, what happens? Something good may be one out of 10 that really sticks. That's one of the things these strategies meetings need to take place with senior leadership and some of your peers, perhaps. But I understand the frustration you have, believe me. I have been associated with the organization for years, sitting in Maria's seat two or three times, and it's extremely difficult because you have a different mission, you have a different patient population, you are in different communities. All these things effect the way you operate.

Ms. Youssouf asked anything else?

Mr. Campbell asked if we need to adopt?

Mr. Russo answered no, we received it.

Ms. Youssouf stated let it be noted, we received the management letter and it was reviewed by the committee.

There being no other business, the meeting was adjourned at 11:13 A.M.

Submitted by,

Ms. Emily Youssouf
Audit Committee Chair

RESOLUTION

Amending the resolution of the Board of Directors (the "Board") adopted in April 2014 authorizing the New York City Health and Hospitals Corporation (the "System") to execute an agreement with KPMG LLP ("KPMG") to perform auditing services and other directly related services for an amount not to exceed $3,487,000 plus a 10% contingency reserve of $340,000 for a total not-to-exceed amount of $3,827,000 with such amendment adding $300,000 to the funding authorized for the contract to accommodate work required to have been performed in connection with the Medicaid Administration grant in order to increase the not to exceed amount of the contract with KPMG to $4,127,000.

WHEREAS, the Board approved a resolution in April 2004 authorizing the System to enter into a contract with KPMG for KPMG to perform auditing services and other directly related services for an amount not-to-exceed $3,827,000 including a $340,000 contingency; and

WHEREAS, the System executed such an agreement with KPMG that will expire upon the conclusion of the routine auditing and associated work for the System's 2017 fiscal year which is anticipated to be approximately the end of June 2018; and

WHEREAS, the System received a grant from the New York City Human Resources Administration ("HRA") to facilitate and encourage the enrollment of eligible individuals in the Medicaid program (the "Grant"); and

WHEREAS, HRA audited the System's performance and expenditures under the Grant; and

WHEREAS, at the System's request KPMG undertook the work of responding to the HRA audit; and

WHEREAS, the cost of the HRA audit related work was approximately $232,000 and the total billed to date by KPMG under its contract is $4,067,630; and

WHEREAS, to enable the System to pay the amounts currently due to KPMG, to restore most of the contingency originally provided in the contract and to ensure adequate funding of the KPMG contract through the end of June 2018, approximately $300,000 is required; and

WHEREAS, the KPMG contract, with its requested increased funding, shall be managed by the Senior Vice President/Chief Financial Officer.

NOW THEREFORE BE IT:

RESOLVED, that the resolution of the Board of Directors adopted in April 2014 that authorized the New York City Health and Hospitals Corporation to execute an agreement with KPMG LLP to perform auditing services and other directly related services for an amount not to exceed $3,487,000 plus a 10% contingency reserve of $340,000 for a total not-to-exceed amount of $3,827,000 be amended to add $300,000 to the funding authorized for the contract to accommodate work required to have been performed in connection with the Medicaid Administration grant in order to increase the not to exceed amount of the contract with KPMG to $4,127,000.

EXECUTIVE SUMMARY
MODIFICATION OF AUTHORIZATION
FOR KPMG, INC. AUDIT CONTRACT
TO ADD ADDITIONAL FUNDING

BACKGROUND: April 2004 the Board of directors approved a resolution authorizing the System to enter into a contract with KPMG for KPMG to perform auditing services and other directly related services for an amount not-to-exceed $3,827,000 including a $340,000 contingency. The work to be covered by such contract was the audit work required by to be completed for the System by regulation and in the normal course of the System's operations. Certain additional limited audits cannot be anticipated however it is customary that limited additional work will be required in over the course of the audit agreement. As it developed, there was not only a need for KPMG to conduct some limited incidental audits which were able to be paid for out of the contract contingency but also a non-financial audit that caused the System to need additional funding in addition to the contingency.

NEED: The work that KPMG was asked to undertake, in addition to its core audit functions and the cost was:

2014 Audit testing for compliance with reporting GASB 65 (Deferred Outflows/Inflows) and GASB 68 (Pension). Additionally, KPMG is asked every 3-4 years by the City to perform a pension census test for use in its actuarial assumptions.	$ 100,090
2015 Audit testing for compliance with reporting GASB 68 (Pension), GASB 72 (Fair Value). KPMG also performed the first 2 audits of the ACO which was newly reported for audit, and required additional test work. MetroPlus additional services were also incurred.	151,140
2016 During the vacancy of the Corporate Comptroller, substantial testing was performed for accounts receivable and revenue and expense recognition issues. MetroPlus and Nursing Home RHCF4 additional work also performed.	166,500

2017 Audit testing for compliance with reporting GASB 68 (Pension), GASB 75 (OPEB), GASB 80 (Blended Units), GASB 82 (Pension) and GASB 85 (Various). KPMG also performed additional test work on revenue recognition for DSRIP, CREP, VBP/QIP, and accrued compensated balances that were reclassified to long and short-term liabilities.	164,900
2014 – 2017 Reduction for unused services for anticipated bond offerings and cost report certifications that had been budgeted for in the	(252,000)
Total Additional Financial Statement Related Work	$330,630

These areas of additional audit work arose in the normal course of the audit agreement and would have been covered by the contingency.

However KPMG was asked to take on an additional project which was of a different type and caused the contingency built into the contract to be exceeded. This additional work involved responding to a CMS audit of the System's Medicaid administration grant. This is a grant that the System received from CMS for the work of enrolling additional patients for Medicaid coverage. The CMS audit requires a time and effort study to justify to CMS the amount that the System billed under the administration grant. The cost of this additional work was $250,000. This work was not, strictly speaking Financial Statement Related Work and its cost had not been anticipated in the budget for the audit contract. The KPMG audit validated the system's time and effort reporting and, if CMS accepts KPMG's findings, H+H expects to collect approximately $77 million from the Medicaid Administration grant for the periods audited.

NYC HEALTH + HOSPITALS

AUDIT COMMITTEE OF THE NYC HEALTH + HOSPITALS BOARD OF DIRECTORS

Corporate Compliance Report
February 7, 2018

NYC HEALTH+ HOSPITALS

AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
Wednesday, February 7, 2018 @ 11:00 AM

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NYC HEALTH+ HOSPITALS

AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
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Corporate Compliance Report
125 Worth Street, Room 532
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I. Operating Procedure 50-1 ("OP 50-1") *Corporate Compliance and Ethics Program*

Background

1) Operating Procedure 50-1 ("OP 50-1"), Corporate Compliance and Ethics Program (the "Program"), was developed to meet certain legal requirements. OP 50-1 was originally promulgated by NYC Health + Hospitals ("the System") in 2009, and subsequently amended in 2010, to add a Disciplinary Policy and Revised Non- Retaliation policy.

2) As reported at the December 7, 2017 meeting of the Audit Committee of the NYC Health + Hospitals Board of Directors (the "Audit Committee"), the Office of Corporate Compliance ("OCC") revised OP 50-1 to comply with legal obligations. As previously noted, OP 50-1 outlines:

- How the Program is to be implemented, managed, enforced, monitored, and otherwise operated; and
- The roles and responsibilities of, and the procedures that must be followed by, each Covered Person to meet his/her obligation to affirmatively participate in the Program.

Status Update

3) The OCC is pleased to announce that on January 5, 2018, OP 50-1 was finalized and formally promulgated by the System, and was subsequently posted on the System's OCC intranet page and on the System's public Policies and Procedures website page.

Efforts to Educate Covered Persons about OP 50-1 and the Program

4) In an effort to inform and educate Covered Persons regarding OP 50-1, on January 19, 2018, the OCC distributed, through a System-wide email communication, a memorandum and PowerPoint presentation to all NYC Health + Hospitals Workforce Members (including those System Agents that fall under the category of Workforce Members) regarding OP 50-1 and the Program, which described and outlined:

- The Scope and Applicability of the Program;
- Key Program Policy Initiatives;
- Legal Requirements of a Compliance Program;
- New and Expanded Areas Covered in the Revised OP 50-1;
- Summary of the Responsibilities of Covered Persons under the Program;
- Summary Educational Tool;
- How to Report Compliance Violations; and
- Responsibilities of Covered Persons to Disseminate OP 50-1.

5) In addition, on Monday, January 22, 2018, all other Covered Persons (*e.g.*, Business Partners and non-Workforce Member Agents) were sent the same memorandum and the aforementioned accompanying attachments.

Ongoing System-wide Training

6) Covered Persons will continue to receive training and education materials regarding the Program, OP 50-1, and the many compliance-related policies and procedures promulgated by the System. Such training and education, which will occur on an ongoing basis, will take place by way of computer-based and in person training efforts, as well as the dissemination of hard copy training materials.

II Compliance Certifications

Legal Background

Social Services Law § 363-d & 18 NYCRR Part 521 – Effective Compliance Program Certification

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

- Describe compliance expectations;
- Implement the operation of the compliance program;
- Provide guidance to Covered Persons (*i.e.*, Workforce Members, Business Partners, and Agents of the System) on dealing with potential compliance issues;
- Identify how to communicate compliance issues to appropriate compliance personnel; and
- Describe how potential compliance problems are investigated and resolved.

Deficit reduction Act of 2005 Certification

8) Under the Deficit Reduction Act of 2005 (the "DRA"), the System is required to establish and disseminate written policies and procedures that inform its Workforce Members (*e.g.*, employees, affiliate employees, personnel, volunteers, students, trainees, appointees, members of the medical staff, and members of the governing body) about NYC Health + Hospitals' internal policies covering fraud, waste, and abuse; the Federal False Claims Act ("FCA") and any similar law under the State of New York that governs false claims and statements; and whistleblower protections under Federal and State laws. The DRA also requires that each System facility that has an employee handbook, include a specific discussion of the laws, the right of employees to be protected as whistleblowers, and the entity's compliance policies in such handbook. These requirements must be met each year no later than September 30th.

[1] *See* 18 NYCRR § 521.3(c)(1).

9) The System has developed the following written policies designed to address fraud, waste, and abuse:

- NYC Health + Hospitals' Corporate Compliance Plan (the "Plan");
- NYC Health + Hospitals' OP 50-1;
- NYC Health + Hospitals' Principles of Professional Conduct ("POPC");
- A Guide to Compliance at NYC Health + Hospitals ("Guide to Compliance"); and
- The Memorandum from the NYC Health + Hospitals Chief Corporate Compliance Officer regarding CMS Medicare Parts C & D Training (the "Medicare Parts C & D Training").

Collectively, these policies address the System's Corporate Compliance Program; the System's prohibition of fraudulent and unethical business practices; and the System's commitment to prevent and detect fraud, waste, and abuse and to deter criminal conduct.

The System must certify each year that it has fulfilled its requirements under the DRA.

Status of Certifications

10) Both the Compliance Program and DRA certifications were successfully completed and submitted by former System Interim President Mr. Stanley Brezenoff in December 2017.

III Monitoring Excluded Providers

Overview of Regulatory Requirements

11) Federal regulations prohibit the allocation of Federal health care program (*e.g.*, Medicaid and Medicare) payments "for an item or service furnished … by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service

knew or had reason to know of the exclusion."[2] Likewise, New York State ("NYS" or the "State") has promulgated billing prohibitions related to services furnished by an excluded provider. Lastly, to maintain an active enrollment status in the Medicare program, the System must certify that it does not employ or contract with individuals or entities that are "excluded from participation in any Federal health care programs for the provision of items and services covered under the programs."[3]

Responsibilities of the System for Sanction List Screening

12) To adhere to these regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General ("OMIG")[4] and the U.S. Health and Human Services Office of Inspector General ("OIG"), each month the OCC reviews the exclusion status of NYC Health + Hospitals' Workforce Members, vendors and New York State Department of Health Delivery System Reform Incentive Payment ("DSRIP") Program Partners.

Office of Foreign Asset Control ("OFAC") Screening

13) To ensure that the System does not conduct business with individuals or entities that are a threat to the security, economy or foreign policy of the United States, the OCC also screens all NYC Health + Hospitals Workforce Members, vendors and DSRIP Partners against the databases of the United States Department of Treasury Office of Foreign Asset Control ("OFAC").[5]

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[2] 42 CFR § 1001.1901 (b); *see* 42 CFR § 1002 (the authority of State agencies to exclude on their own initiative, regardless of whether the OIG has excluded an individual or entity).
[3] 42 CFR § 424.516 (a) (3); *see* 42 CFR § 424.535(a) (2) (regarding the Center for Medicare and Medicaid Services' option to revoke enrollment and billing privileges due to exclusion from Medicare, Medicaid or any federal program); 42 USC § 1320c-5 (regarding obligations of health care practitioners and providers and the Secretary of Health and Human Services' right to exclude a person or entity for failing to meet the obligations).
[4] *See* DOH Medicaid Update, April 2010, Vol.26, No. 6; OMIG webinar #22, OMIG Exclusion and Reinstatement Process, available at https://omig.ny.gov/resources/webinars/811-omig-webinar-22, (Slide 20 (Sept. 2014).
[5] *See* Frequently Asked Questions: Who must comply with OFAC regulations? United States Treasury website available at, https://www.treasury.gov/resource-center/faqs/Sanctions/Pages/faq_general.aspx.

Exclusion and Sanction Screening Report December 1, 2017 through January 20, 2018

14) Since the OCC last reported excluded provider activities at the December 2017 Audit Committee meeting, there have been no new excluded or disciplined providers identified.

Death Master File and National Plan and Provider Enumeration System Screening

15) The Centers for Medicaid and Medicare Services' ("CMS") regulations[6] and the contractual provisions found in managed care organization ("MCO") provider agreements[7] both require screening of NYC Health + Hospitals' Workforce Members and certain Business Partners and Agents (collectively "Covered Persons") to ensure that none of these Covered Persons are using the social security number ("SSN") or National Provider Identifier ("NPI") number of a deceased person in an effort to hide their true identity. This screening may be accomplished by vetting the SSNs and NPIs of Covered Persons through the Social Security Administration Death Master File ("DMF") and the National Plan and Provider Enumeration System ("NPPES"), respectively.

16) The OCC currently screens the DMF and NPPES files regularly as part of its sanction screening process. No providers have been identified on the DMF or NPPES since the last Audit Committee meeting in December 2017.

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[6] *See* 42 CFR § 455.436; *see also*, CMS' Toolkit to Address Frequent Findings 42 CFR § 455.436 Federal Database Checks, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

[7] *See* New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts, Appendix, Revised April 1, 2017, at 4, available at: https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/standard_clauses_revisions.pdf, ("Provider … agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES)").

IV. Privacy Incidents and Related Reports – Fourth Quarter Reports

Reportable Privacy Incidents for the Fourth Quarter of Calendar Year 2017 (October 1, 2017 – December 31, 2017 – hereinafter "4th Quarter")

17) During the period of October 1, 2017 through December 31, 2017, thirty-three (33) privacy complaints were entered into the ID Experts RADAR Incident Tracking System. Of the thirty-three (33) complaints entered in the tracking system, eleven (11) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy Operating Procedures, specifically OP 240-15 "HIPAA Privacy Safeguards Policy" and OP 240-28 "HIPAA Policy on Uses and Disclosures for Treatment, Payment and Healthcare Operations"; seven (7) were determined to be unsubstantiated; seven (7) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures; and eight (8) are still under investigation. Of the eleven (11) incidents confirmed as violations, seven (7) were determined to be breaches.

Breach Defined

18) A breach is an impermissible use, access, acquisition or disclosure (collectively referred to as "use and/or disclosure") under the HIPAA Privacy Rule that compromises the security and privacy of protected health information ("PHI") maintained by the System or one of its business associates.[8]

19) Pursuant to 45 CFR § 164.402(2), the unauthorized use and/or disclosure of PHI is presumed to be a breach unless the System can demonstrate, through a thorough, good faith risk assessment of key risk factors, that there is a low probability that the PHI has been compromised.[9]

[8] *See* 45 CFR § 164.402.
[9] *See* 45 CFR § 164.402(2); *see also* 78 Fed. Reg. 5565, 5643 & 5695 (Jan. 25, 2013).

Factors Considered When Determining Whether a Breach Has Occurred

20) Under HIPAA regulations, at a minimum the following four key factors must be considered to determine whether there is greater than a low probability that a privacy and/or security incident involving PHI has resulted in the compromise of such PHI:[10]

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

Reportable Breaches in the 4th Quarter

21) As stated above, there were seven (7) reportable breaches in the 4th Quarter. Below is a summary of these breaches:

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

  Incident: The incident occurred on April 27, 2017, when an individual in the process of being investigated by the NYC Department of Investigations ("DOI") was found to be in possession of PHI belonging to an Elmhurst patient. The incident was referred to the OCC by the DOI on October 3, 2017. The individual was not an employee of, and had no connections with, NYC Health + Hospitals. Rather, he was at Elmhurst attempting to approach and solicit patients for the services of a law firm. The individual was stopped by Elmhurst Hospital Police who observed his activity and found that he was holding papers containing PHI. The Hospital Police then referred the matter to the DOI. The

[10] *See* 45 CFR § 164.402(2)(i-iv).

PHI included information such as discharge instructions, including medications and procedures performed at Elmhurst.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on December 1, 2017.

Mitigation: Solicitation activities are strictly prohibited at NYC Health + Hospitals facilities and there is active monitoring in place to detect and deter these types of activities. It was due to the existence of these very controls that we were able to apprehend the individual.

- **NYC Health + Hospitals/Coney – October 2017**

Incident: This incident, which occurred on October 4, 2017, and was discovered on the same day, involved the unauthorized access of PHI by a Coney Workforce Member. The patient was seen in the Coney emergency department, and requested an access audit report of his record to see if any inappropriate access of his record had occurred. A review of the access audit report concluded that one employee accessed the electronic record without authorization. The PHI accessed included demographic information such as date of birth, home address and contact phone number.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on October 25, 2017.

Mitigation: The employee who accessed the information was counseled and completed comprehensive retraining in HIPAA policies for maintaining the confidentiality of patient information. This incident also was recorded in the employee's employment file.

- **NYC Health + Hospitals/Queens – October 2017**

Incident: This incident, which occurred on October 10, 2017, and was discovered on October 25, 2017, involved a patient's parent being given a

health examination form of another patient by the registration clerk. The form included PHI such as name, address, date of birth, immunizations, and general medical history. Attempts to retrieve the information from the individual were unsuccessful.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on December 6, 2017.

Mitigation: The workforce member involved in this incident was counseled and provided with focused privacy training. Additional training refreshers will be conducted in all patient-facing areas to remind the staff to verify and confirm that information is given to the right individual/s.

- **NYC Health + Hospitals/Bellevue – October 2017**

Incident: The incident, which occurred on October 11, 2017 and was discovered on the same day, involved the unauthorized access of thirty-nine (39) patient records. A Bellevue physician inadvertently left paper patient rounding records containing PHI in one of the patient rooms, where they were visible to individuals who were not authorized to view them. The PHI included information such as date of birth, medical record number, treatment, and diagnosis information. It was found that one of the patient's mother had taken the papers home, assuming they were her child's records. When the records were recovered, information on three patients was found to be missing.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notifications were sent to the affected individuals on December 5, 2017.

Mitigation: The physician involved in this incident was counseled and provided with focused privacy training. The entire department received HIPAA refresher training. Additionally, a confidential shredding bin was placed within the department for the physicians to dispose of confidential materials after their rounds.

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

Incident: This incident, which occurred and was discovered on November 14, 2017, involved a patient mistakenly receiving forty-one (41) pages of medical records from Elmhurst's Health Information Management ("HIM") department belonging to another patient. The patient who received the records reported the incident to the HIM department but refused to return the documents to staff when requested. The PHI disclosed included a treatment summary.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on December 1, 2017.

Mitigation: The staff within HIM were counseled and trained to avoid making errors while providing medical records to patients.

- **NYC Health + Hospitals/North Central Bronx – December 2017**

Incident: This incident, which occurred on November 19, 2017, and was discovered on December 6, 2017, involved a volunteer who placed confidential documents with patient information in her car. Her car was stolen and subsequently returned; however, one document was missing. The missing document included PHI such as name, address, date of birth, and possibly the patient's social security number.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on January 17, 2017.

Mitigation: The volunteer, and the entire team with which she worked, was instructed not to take any documents offsite. In addition, all will be retrained on HIPAA privacy policies and procedures.

- **NYC Health + Hospitals/North Central Bronx – December 2017**

Incident: This incident occurred on June 8, 2017, and was discovered on December 29, 2017. It involved a patient who, upon discharge from the hospital in June, received a discharge summary belonging to another patient. An advocate of the discharged patient alerted the hospital of the incident in December. The disclosed PHI included the patient's name and medical record number.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on January 22, 2018.

Mitigation: Workforce members involved in this incident will be retrained on HIPAA policies and procedures as they relate to maintaining confidentiality of patient information.

Office of Civil Rights ("OCR") Inquiries Regarding Potential and/or Determined Privacy Incidents During the 4th Quarter

22) There were no inquiries initiated by the OCR in the 4th Quarter of 2017.

V. Compliance Reports – Fourth Quarter Reports

Summary of 4th Quarter Reports

23) For the 4th quarter of CY2017 (October 1, 2017 to December 31, 2017), there were ninety-six (96) compliance-based reports of which one (1) (1%) was classified as a Priority "A";[11] twenty-nine (29) (30.2%) were classified as Priority "B"; and sixty-six (66) (68.8%) were classified as Priority "C" reports. For purposes here, the term "reports" means

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

compliance-based inquiries and compliance-based complaints. The ninety-six (96) reports were received from the below-listed sources:

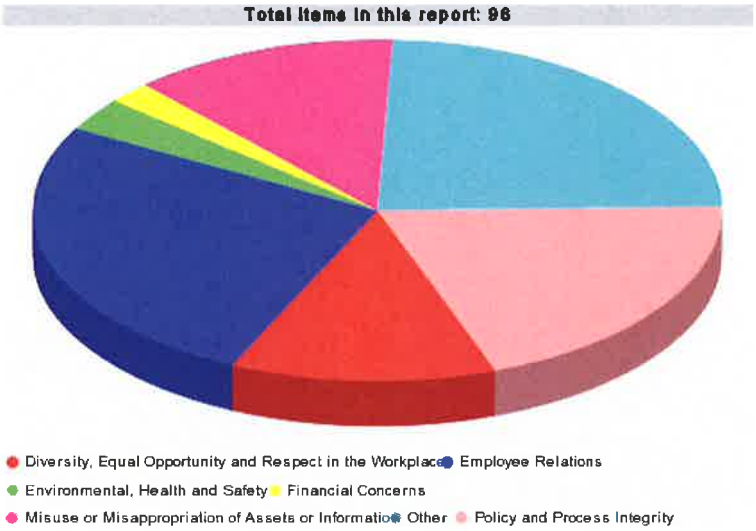
i) PRIMARY ALLEGATION SOURCES

Source	Frequency (Percentage)
E-Mail	14.0 (14.6 %)
Face to Face	7.0 (7.3 %)
Hotline	64.0 (66.7 %)
Mail	2.0 (2.1 %)
Telephone	3.0 (3.1 %)
Voicemail	1.0 (1 %)
Web Submission	5.0 (5.2 %)
Totals	96.0 (100%)

ii) PRIMARY ALLEGATION CLASS

The class and nature of the reports filed may be categorized as follows:

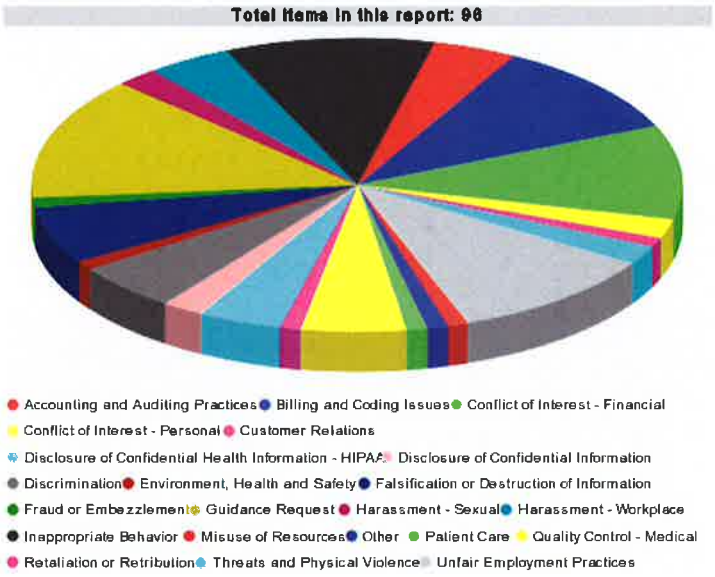
Primary Allegation Class	Frequency (Percentage)
Diversity, Equal Opportunity and Respect in the Workplace	12.0 (12.5 %)
Employee Relations	25.0 (26 %)
Environmental, Health and Safety	3.0 (3.1 %)
Financial Concerns	2.0 (2.1 %)
Misuse or Misappropriation of Assets or Information	12.0 (12.5 %)
Other	23.0 (24 %)
Policy and Process Integrity	19.0 (19.8 %)
Totals	96.0 (100%)



iii) PRIMARY ALLEGATION TYPE

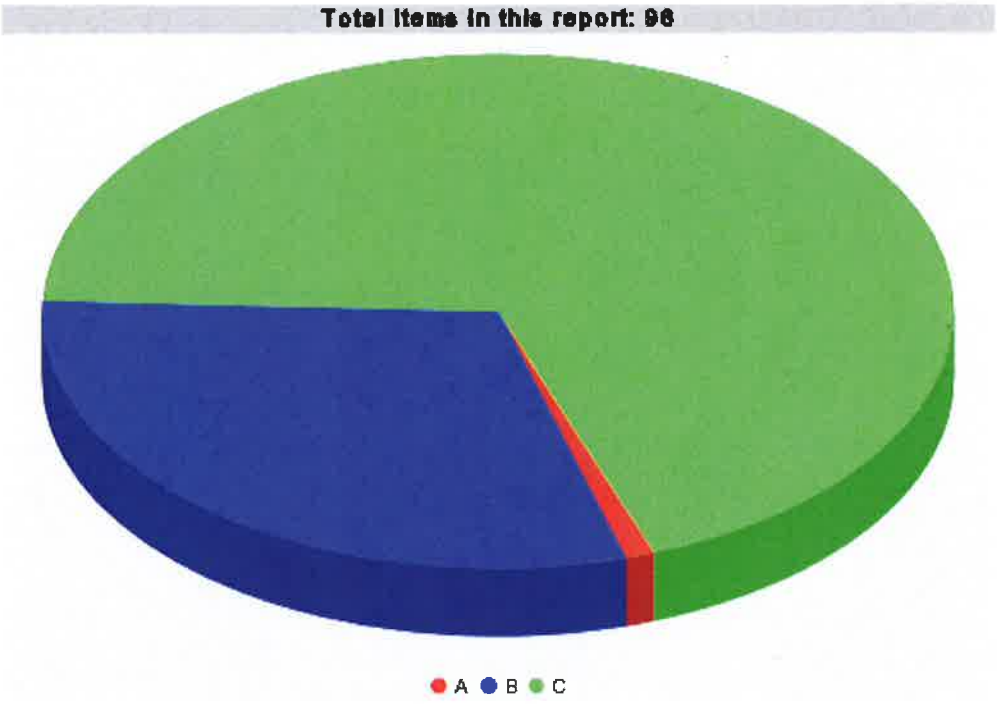
Primary Allegation Type	Frequency (Percentage)
Accounting and Auditing Practices	1.0 (1 %)
Billing and Coding Issues	1.0 (1 %)
Conflict of Interest - Financial	1.0 (1 %)
Conflict of Interest - Personal	5.0 (5.2 %)
Customer Relations	1.0 (1 %)
Disclosure of Confidential Health Information - HIPAA	4.0 (4.2 %)
Disclosure of Confidential Information	2.0 (2.1 %)
Discrimination	5.0 (5.2 %)
Environment, Health and Safety	1.0 (1 %)
Falsification or Destruction of Information	6.0 (6.2 %)
Fraud or Embezzlement	1.0 (1 %)
Guidance Request	13.0 (13.5 %)
Harassment - Sexual	2.0 (2.1 %)
Harassment - Workplace	4.0 (4.2 %)
Inappropriate Behavior	10.0 (10.4 %)
Misuse of Resources	4.0 (4.2 %)
Other	10.0 (10.4 %)
Patient Care	10.0 (10.4 %)
Quality Control - Medical	2.0 (2.1 %)
Retaliation or Retribution	1.0 (1 %)
Threats and Physical Violence	2.0 (2.1 %)

Unfair Employment Practices	10.0 (10.4 %)
Totals	96.0 (100%)



iv) PRIORITY CLASSIFICATION

Classification	Frequency (Percentage)
A	1.0 (1 %)
B	29.0 (30.2 %)
C	66.0 (68.8 %)
Totals	96.0 (100%)



Review of Priority "A" Report

24) As noted above, there was one (1) Priority "A" report. It is summarized as follows:

NYCHHC-17-10-0029: On October 27, 2017, the OCC received a letter from the Reporter alleging mistreatment and misconduct in the psychiatric treatment of her son at NYC Health + Hospitals/Bellevue ("Bellevue"). The Reporter, who sent copies of the letter to the New York State Department of Health's Office of Professional Medical Conduct, the New York State Department of Education's Office of Misconduct Enforcement, New York City Health + Hospitals Board Member Gordon Campbell and Bellevue Executive Director, William Hicks, and Chief Operating Officer, Michael Rawlings, alleged serious concerns regarding her son's care, including inappropriate treatment, inappropriate prescribing of medications, and provider misconduct. On October 27, 2017, the OCC Chief Corporate Compliance Officer referred the matter to Mr. Hicks by email and telephone for Bellevue's review and response.

The OCC was advised by Christopher Roberson, Associate Director of Public Affairs at Bellevue, that a review of the allegations found that the medical services provided were appropriate to the patient's condition and that there was no factual basis for the claims presented. Mr. Roberson advised that a final report is being prepared for Mr. Hicks and will be submitted shortly. The case is open pending receipt of the final report.

Review of Retaliation Report

25) As noted above, there was one (1) retaliation report. It is summarized as follows:

NYCHHC-17-12-0003: On December 3, 2017, the OCC Helpline received an anonymous call from a Reporter who alleged that a supervisor at NYC Health + Hospitals/Queens ("Queens") was arbitrary and discriminatory in her management of the department. More specifically, the Reporter alleged that she was unfairly denied promotion and required to provide proof of her vacation plans before her leave would be approved.

The OCC was advised by the Queens human resources department that their review of the matter revealed an additional workforce member had similar complaints concerning the same supervisor. As a result, human resources has sought to remove the supervisor temporarily from her position and has requested that Central Payroll assign someone to the facility to assume the supervisor's role because "the work cannot be supported by anyone else currently in the department." Human resources expects that the inquiry should be completed within the next two weeks.

VI. Updating Information Governance/HIPAA Privacy and Security Operating Procedures

Overview

26) NYC Health + Hospitals has implemented numerous measures to safeguard PHI. Specifically, the System has established an information governance program to ensure the confidentiality and security of PHI. Some of the key measures implemented to ensure compliance with applicable privacy and data security laws include, without limitation: (i) the promulgation of policies and procedures that safeguard the privacy and security of PHI;

(ii) the establishment of training programs to communicate and provide guidance to the System's workforce on the importance of safeguarding PHI; (iii) the conducting of random corporate walk-throughs by senior compliance personnel to ensure data security quality across the System; and (iv) the procurement of outside privacy and security auditors/consultants to provide HIPAA gap analyses and audits of the privacy and security protocols currently in place System-wide.

Review of Privacy OPs

27) As discussed at the December 2017 Audit Committee meeting, the OCC conducted a comprehensive review of its privacy and security OPs. Based on this review, the OCC reported that the following privacy topics, although already embodied in the System's policies and procedures, have been updated and, subject to legal counsel review, are expected to be presented to the President for approval on or by February 28, 2018.

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

VII Transition of Privacy Functions from Facilities to OCC

28) Historically, HIPAA privacy-related duties and functions were handled within each facility by the respective Facility Privacy Officers, in addition to their other facility duties and responsibilities. In an effort to centralize and streamline the HIPAA reporting and investigation process, however, in December 2017, the OCC began transitioning the privacy-related duties and functions from the Facility Privacy Officers to the OCC's Compliance Officers. These duties and functions include, without limitation, documenting and investigating all allegations of HIPAA violations at their facilities, engaging in mitigation efforts following a breach of PHI at their facilities, and providing initial and ongoing HIPAA education and training to their facilities' Workforce Members.

29) As a result, the HIPAA privacy-related duties and functions are being carried out in a more efficient and effective manner, and the OCC is able to assume better oversite of them. The transition was very well received by the facilities' leadership, the Facility Privacy Officers, and the OCC's Compliance Officers.

VIII. Review and Updating of Compliance Policies and Procedures

Current OP Reviews

30) In accordance with Federal and State compliance guidelines, as well as 10 NYCRR § 405.3 (d)(6), the OCC is currently reviewing its compliance policies and procedures to determine whether modification is necessary to meet applicable law, compliance best practice standards, and the System's transformation and evolving vision. In addition to finalizing OP 50-1, the following OPs have undergone final legal review, and are expected to be ready for the President's signature by early March 2018.

- OP 50-2 (The Prohibition of Activities that Violate the Civil Monetary Penalties Law and/or Result in the Imposition of Civil Monetary Penalties);
- OP 50-3 (Compliance with the Federal and State False Claims Acts, and Federal and State Laws Related to the Commission of Health Care Fraud); and
- OP 50-6 (Emergency Medical Treatment and Active Labor Act ("EMTALA")).

31) In addition to finalizing these Operating Procedures, the Compliance Plan and Guide to Compliance will be updated accordingly to reflect the finalization of these Operating Procedures.

Upcoming OP Reviews

32) In addition to the above mentioned OPs, the following OPs are in the process of being updated for legal review, and are expected to be ready for the President's signature by the end of March 2018:

- OP 50-5 (Mandatory Reporting and Refunding of Overpayments); and
- OP 50-7 (Excluded Provider).

IX. Status Update – DSRIP Compliance Activities

Background and Legal Requirements Regarding DSRIP Compliance Training

33) Pursuant to State regulations, NYC Health + Hospitals is required to adopt and implement an effective compliance program, which includes the provision of periodic compliance "training and education of all affected employees and persons associated with [NYC Health + Hospitals] … on compliance issues [and] expectations of the compliance program".[12] Per OMIG compliance guidance, these compliance training and education requirements extend to the DSRIP Program.

34) As reported to the Audit Committee in December 2017, NYC Health + Hospitals/OneCity Health ("OneCity Health"), as a Performing Provider System ("PPS") lead in the DSRIP Program, is responsible for taking "reasonable steps to ensure that [M]edicaid funds distributed as part of the DSRIP program are not connected with fraud, waste, and abuse. It is reasonable for a PPS Lead to consider its network performing providers' program integrity systems when dedicating resources and developing the PPS Lead's systems."[13] To satisfy its compliance obligations as a PPS Lead, and to fulfill the requirements of the OMIG DSRIP compliance guidance, OneCity Health developed a compliance Attestation form, which is designed to assess its performing providers' ("Partners") compliance with the program requirements.

OneCity Health Compliance Attestation

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[12] 18 NYCRR §521.3[c][3]; *see* 18 NYCRR § 521.1; Social Services Law § 363-d [2][c].
[13] Office of the Medicaid Inspector General Delivery System Reform Incentive Payment ("DSRIP") Program DSRIP Compliance Guidance 2015-01 –revised – Special Considerations for Performing Provider System ("PPS") Leads' Compliance Program available at: https://www.omig.ny.gov/images/stories/compliance_alerts/20150901_DSRIP_CompGuidance_2015-01_Rev.pdf.

35) OneCity Health Partners must certify annually to OneCity Health that they have met their DSRIP compliance training obligations and certain other compliance-related obligations. On or before February 7, 2018, the OCC will distribute a Memorandum to OneCity Health Partners with a Compliance Attestation ("Attestation") attached thereto. The Attestation, which provides OneCity Health and the OCC with a critical snapshot of the compliance foundation of its DSRIP partners, must be completed by all OneCity Health Partners and returned to the OCC by close of business on June 30, 2018.

36) The February OCC Memorandum will cover the following topics:

- Why the Attestation is required;
- What the Attestation does;
- The key components of the Attestation; and
- Instructions on completing and submitting the Attestation to the OCC.

37) OneCity Health Partners are asked to confirm they have completed the compliance training requirements and specify the method by which the training was conducted.

38) The NYC Health + Hospitals' POPC is a guide that sets forth the System's compliance expectations and describes NYC Health + Hospitals' standards of professional conduct as well as its efforts to prevent fraud, waste, and abuse. In the Attestation, Partners are asked a series of questions to confirm whether or not they have met the requirements outlined in the POPC, including the following key obligations:

- Adopt the POPC or their own code of conduct that includes the POPC's core objectives or substantially similar compliance goals;
- Refrain from engaging in unprofessional conduct, as described in Section VI of the POPC, which includes, for example, the following:
  - The misuse or misallocation of DSRIP funds; and

- Hiring or contracting with persons or entities excluded from participation in Federal health care programs;

- Timely report to NYC Health + Hospitals any violation of the POPC of which it becomes aware; and
- Fully cooperate, to the extent applicable, with any investigation by NYC Health + Hospitals or, if required, any governmental agency.

39) The OCC utilizes the following two OMIG-mandated compliance certifications to help it assess the compliance program integrity of OneCity Health Partners:

- The New York Social Services Law § 363-d Certification; and
- The Deficit Reduction Act of 2005 Certification.

40) To this end, The Attestation asks a series of questions to determine whether a Partner is required to submit to OMIG one or both of the two aforementioned certifications, and if so, whether the Partner has actually carried out this requirement.

New York Social Services Law § 363-d and 18 NYCRR Part 521

41) New York Social Services Law ("SSL") § 363-d and its implementing regulations found at 18 NYCRR Part 521, require certain providers to annually certify through the OMIG website that they have an "effective" compliance program. Certifications are required by provider organizations that:

- Are subject to Public Health Law Article 28 or 36;
- Are subject to Mental Hygiene Law Article 16 or 31; or
- Claim, order, bill or receive at least $500,000 within a 12 month period from Medicaid.[14]

42) The Attestation requires Partners who confirmed that they completed the SSL § 363-d certification to include proof of such completion (*e.g.*, a copy of the electronic

[14] *See* 18 NYCRR §§ 521.2 and 521.3.

confirmation receipt that OMIG provides to each Partner upon their SSL § 363-d certification submission) along with their completed Attestation.

Deficit Reduction Act of 2005

43) The DRA requires providers who receive or make $5 million or more in direct Medicaid payments to annually certify though the OMIG website that they have:[15]

- Established and disseminated to all their employees, including management, and any contractor or agent of their provider organization, written policies that provide detailed information about[16]:
  - The Federal False Claims Act, remedies for false claims and statements, and State laws pertaining to civil or criminal penalties for false claims and statements;
  - Whistleblower protections under the Federal False Claims Act and State laws;
  - The role of the Federal False Claims Act and State law in preventing and detecting fraud, waste, and abuse in Federal health care programs; and
  - The provider organization's policies and procedures for detecting fraud, waste, and abuse; and
- Included the following information in the provider organization's employee handbook (if one exists):
  - Information about the Federal False Claims Act and comparable New York State laws;
  - A specific discussion of the rights of provider organizations' employees to be protected as whistleblowers; and
  - A specific discussion of the provider organization's policies and procedures for detecting fraud, waste and abuse.

[15] 42 U.S.C. § 1396a (a)(68).
[16] *See id.*

44) The Attestation requires Partners who confirmed that they completed the DRA certification to include proof of the same (*e.g.*, a copy of the electronic confirmation receipt that OMIG provides to each Partner upon their DRA certification submission) along with their completed Attestation.

OCC Memorandum dated December 28, 2017, and DSRIP Compliance Training Materials

45) On December 28, 2017, the OCC distributed a Memorandum and correlating Compliance Training and Education PowerPoint presentation (the "Training PowerPoint") to all Partners in OneCity Health, reminding them of their DSRIP program compliance training and education requirements. The Memorandum addressed the following topics:

- DSRIP compliance training and education requirements under New York State law and OMIG DSRIP compliance guidance;
- A brief description of training materials and information previously provided to OneCity Health Partners during the calendar year 2017; and
- An overview of the training presentation, *Delivery System Reform Incentive Payment Program Compliance Training and Education*, with instructions that the training presentation can be used by Partners to meet their DSRIP compliance training obligations.

46) Partners were instructed that the Training PowerPoint could be utilized to train their personnel associated with or affected by the DSRIP Program in one or more of the following three ways:

- The development of a presentation for in-person/live DSRIP compliance and education training;
- The incorporation of the content of the Training PowerPoint in the Partners' existing compliance training computerized or otherwise automated training modules; or

- The distribution of the Training PowerPoint to their workforce members involved with or otherwise affected by the DSRIP Program.

47) The Training PowerPoint covered the following core topics:

- What is DSRIP and who are the key players?
- What is the NYC Health + Hospitals/OneCity Health Performing Provider System?
- Why is the establishment of compliance program beneficial?
- What are the legally required elements of a compliance program?
- With regard to the required compliance program elements, what are the special considerations for DSRIP compliance?
- What are the definitions of the terms Fraud, Waste & Abuse and corresponding examples of the same?
- What are some of the Federal laws covering Fraud, Waste and Abuse that OneCity Health Partners should be familiar with?
- How can OneCity Health Partners report a DSRIP-related compliance issue or concern?

OneCity Health Partner Webinar Regarding DSRIP Compliance Training

48) OneCity Health also held a compliance training webinar with OneCity Health Partners on January 9, 2018, which included, among other important topics, a presentation by the OCC on DSRIP compliance training requirements. During the webinar, Partners were provided with further information on DSRIP compliance training requirements and how to meet them. Partners were also informed that the DSRIP compliance training materials were posted on the OneCity Health website.

Previous Training and Education Disseminated to OneCity Health Partners

49) OneCity Health provided compliance training materials and information to OneCity Health partners throughout the 2017 calendar year. The following summarizes those 2017 training efforts.

Deficit Reduction Act ("DRA") of 2005

50) On September 28, 2017, the OCC provided all OneCity Health Partners with a memorandum concerning the Deficit Reduction Act ("DRA") of 2005, wherein Partners were informed of: (i) NYC Health + Hospitals' internal policies covering the prevention and detection of fraud, waste, and abuse; (ii) the Federal False Claims Act and any similar law under the State that governs false claims and statements; and (iii) whistleblower protections under Federal and State law. As part of meeting compliance training requirements, OneCity Health Partners were instructed, if they had not already done so, to disseminate the DRA memorandum to their workforce members who are involved with or otherwise affected by the DSRIP program.

Corporate Compliance and Ethics Week Message from the Chief Corporate Compliance Officer

51) On November 6, 2017, the System's Chief Corporate Compliance Officer distributed to the System's Workforce Members, Business Partners (including OneCity Health Partners), and Agents, a message commemorating National Corporate Compliance and Ethics Week, November 5-11, 2017. The message asked for support of this year's theme "Make Good Choices," and encouraged the Workforce Members, Business Partners, and Agents to continue to perform their duties, functions, and responsibilities in a fair and honest manner. To that end, accompanying the message was the NYC Health + Hospitals' Principles of Professional Conduct ("POPC"), which is a guide that sets forth the System's compliance expectations, standards of professional conduct, and commitment to comply with applicable Federal and State law.

CMS/Medicare Parts C and D General Compliance Training

52) On December 28, 2017, the System provided its Workforce Members, Business Partners (including, without limitation, OneCity Health Partners), and Agents a Memorandum that outlined the CMS' compliance training and education requirements that the System must satisfy in its role as a provider under contract with Medicare Advantage Organizations ("MAOs"). Examples of MAOs include MetroPlus, Aetna, Fidelis, Empire Blue Cross Blue Shield, Emblem Health, Healthfirst, and United Healthcare, each of which has a provider agreement with the System. Attached to the Memorandum was the *CMS/Medicare Parts C and D General Compliance Training* ("CMS Compliance Training").

53) The main learning objective of the CMS Compliance Training is to ensure that all Workforce Members, Business Partners, and Agents recognize how: (i) a compliance program operates; and (ii) compliance program violations should be reported. The CMS Compliance Training also places an emphasis on ethical behavior.

Audit of OneCity Health DSRIP Program by Outside Auditor

54) As reported at the December 2017 Audit Committee meeting, responses to a Request For Proposal ("RFP") from Outside Auditing Firms to audit the OneCity Health DSRIP Program were due on December 15, 2017. Two responses were received in response to the RFP. The five-member committee assembled to review the RFP responses met on February 5, 2018, to review the responses to the RFP.

X. Status Update - HHC ACO, Inc. Compliance Activities

Background of HHC ACO, Inc.

55) Accountable Care Organizations ("ACOs") are groups of health care providers who come together under an arrangement authorized by the Affordable Care Act to coordinate care, reduce costs and improve quality for their patients. These arrangements link the payment for caring for patients covered by Medicare fee-for-service to their health outcomes. During the course of the year CMS provides reimbursement for care provided to these patients. At the end of the year, the costs of providing such care are reconciled with a benchmark of costs. If the total cost of care provided to Medicare patients is lower than the benchmark, and the quality of care provided meets or exceeds certain outcome standards, the ACO earns a bonus payment based on the savings realized during that year. During 2016, HHC ACO, Inc. ("HHC ACO") achieved a quality score of 90%, reduced costs to Medicare by more than $31 million, and generated shared savings incentive payments of nearly $14 million over the four years it participated in the program.

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

56) As reported at the December 2017 Audit Committee meeting, on October 5, 2017, HHC ACO submitted an application to the New York State Department of Health ("DOH")

seeking approval for an "all payer" ACO that includes Medicaid, commercial insurance and Medicare Advantage patients. That application is still pending. Currently, HHC ACO only provides care to Medicare fee-for-service patients. If the application is approved by DOH, this expanded ACO will cover a much larger patient population. As part of the application, the OCC provided as exhibits the following three draft documents:

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

HHC ACO Compliance Plan

ACO Compliance Plan Requirements

57) ACOs are formed under the Medicare Shared Savings Program ("MSSP"), pursuant to the MSSP regulations at 42 CFR Part 425. These regulations require that all ACOs have a Compliance Plan, which must include at least the following five elements:[17]

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

[17] *See* 42 CFR 425.300 (a)(1-5).

- Compliance training for the ACO, the ACO participants, and the ACO providers/suppliers; and

- A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

The MSSP regulations also require that "[a]n ACO's compliance plan must be in compliance with and be updated periodically to reflect changes in law and regulations."[18]

HHC ACO's Compliance Plan

58) The OCC recently revised the draft HHC ACO Compliance Plan, and circulated it to the HHC ACO Board of Directors on December 29, 2017. The Compliance Plan outlines how the HHC ACO will satisfy applicable legal and regulatory requirements, including without limitation, the five (5) MSSP compliance plan elements described above. The HHC ACO Compliance Plan addresses, without limitation, the following topics:

- Development of HHC ACO Compliance Plan;
- Required Elements of an Effective ACO Compliance Program;
- MSSP Regulatory Requirements;
- Overview of New York State Accountable Care Organizations;
- Background of HHC ACO, Inc.;
- HHC ACO, Inc. Governance;
- HHC ACO, Inc. Participation Agreements;
- ACO Regulatory Requirements;
- Conflicts of Interest;
- HHC ACO, Inc. Records Management Program;
- New York State Public Authorities Law; and
- Reporting HHC ACO, Inc. Compliance Issues, and Non-Retaliation Policy

<u>Adoption of the HHC ACO Standards of Conduct by HHC ACO Board of Directors</u>

59) As reported at the December 2017 Audit Committee meeting, the NYC Health + Hospitals POPC was adopted by the NYC Health + Hospitals Board of Directors in April

[18] 42 CFR § 425.300 (b)(2).

2016. When the POPC was being developed it was determined by the OCC and legal counsel that because of the unique compliance and regulatory requirements for ACOs, a HHC ACO Standards of Conduct ("SOC") modeled on the POPC should be developed. Accordingly, the OCC developed a draft HHC ACO Standards of Conduct for use by HHC ACO staff, participants and providers/suppliers.

60) The HHC ACO Board of Directors formally adopted the HHC ACO Standards of Conduct by resolution on December 18, 2017. The SOC is a guide which sets forth HHC ACO's compliance expectations and commitment to comply with all applicable Federal and State laws. It also describes HHC ACO's standards of professional conduct and efforts to prevent fraud, waste, and abuse.

61) The SOC applies to and governs the conduct of all HHC ACO Personnel. HHC ACO Personnel is defined to include the following: (i) HHC ACO Participants (as defined in 42 CFR Part 425) that have entered into Participation Agreements with HHC ACO, and HHC ACO Providers/Suppliers (as defined in 42 CFR Part 425); and (ii) other individuals or entities that have entered into agreements with HHC ACO for the performance of functions or services related to HHC ACO's activities. Although many HHC ACO Personnel are already covered by the POPC, the SOC will serve as a supplemental guidance for HHC ACO Personnel with more specific information about MSSP compliance requirements.

62) Some core objectives of the SOC include, but are not limited to, the following:

- Deliver seamless, coordinated, high quality care to Medicare Fee-for-Service beneficiaries linked to participating primary care providers through an organized group of health system affiliated physicians and other healthcare providers who have agreed to:

  - Work together to treat a defined population of Medicare Fee-for-Service beneficiaries across care settings, including primary and specialty care, hospitalizations and long-term care; and

  - Become accountable for the quality, cost, and overall care delivered to the defined population of beneficiaries;

- Prevent, identify, and correct unlawful and unethical behavior and fraud, waste, and abuse:

  - Adhere to all applicable provisions of Federal and State law, including, but not limited to, the Federal MSSP regulations at 42 CFR Part 425; and the HHC ACO Compliance Program, including provisions that require reporting of violations to appropriate parties; and

- As a condition of employment or contract (or other agreement) with HHC ACO, comply with the SOC and, where appropriate, other HHC ACO policies that relate to the types of services, duties, functions, and products that such HHC ACO Personnel provide.

63) Some examples of HHC ACO unprofessional conduct found in the SOC include, but are not limited to, the following:

- Conducting unlawful marketing practices to enroll ACO beneficiaries into the HHC ACO including, but not limited to, engaging in unlawful beneficiary inducements; and

- Avoiding At-Risk Patients[19], including those patients who: (i) have a high risk score on the CMS-HCC risk adjustment model; (ii) have one or more chronic conditions; (iii) are considered high cost due to hospital/Emergency Department utilization; (iv) are dual eligible for Medicare and Medicaid; (v) have a disability that entitles such patients to Medicaid; or (vi) have a mental health disorder or a substance abuse disorder[20].

HHC ACO Compliance Training and Education

64) The OCC prepared an HHC ACO Compliance Training and Education Memorandum, with a corresponding PowerPoint training presentation, which was circulated to the HCC ACO Board of Directors on December 29, 2017. The Memorandum

[19] *See* 42 CFR § 425.20
[20] 42 CFR § 425.316(b).

and PowerPoint are intended to train HCO ACO Personnel on compliance-related topics. The PowerPoint has the following five (5) sections:

- Introduction to HHC ACO;
- HHC ACO Compliance Requirements and the HHC ACO Compliance Plan;
- Medicare Shared Savings Program ("MSSP") Overview;
- Fraud, Waste and Abuse & Relevant Laws; and
- Reporting ACO Compliance Issues.

65) HHC ACO participants are expected to complete these compliance training and education requirements through in-person/live training, incorporation of the content of the PowerPoint into the HHC ACO participant's existing compliance training, or distribution of the PowerPoint to HHC ACO Personnel.