



AUDIT COMMITTEE
MEETING AGENDA

April 12, 2018
12:00 P.M.

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

CALL TO ORDER

Ms. Emily A. Youssouf

- Adoption of Minutes February 7, 2018

Ms. Emily A. Youssouf

ACTION ITEMS

- Resolution

PV Anantharam
Jay Weinman

Authorizing New York City Health and Hospitals Corporation (the "System") to execute an agreement with Grant Thornton, LLP ("Grant Thornton") to provide auditing services over a four year term at a total cost throughout the term not to exceed \$4,452,225, including a 15% contingency fee for billable services.

- Resolution

Ms. Catherine Patsos

Approving the designation of Sheetal Sood, Senior Executive Compliance Officer, as the New York City Health + Hospitals (the "System") Record Management Officer ("RMO"), as that term is defined under New York State Education Department regulations found at 8 NYCRR § 185.1(a), to coordinate the development of and oversee the System's records management program in accordance with the requirements set forth under Article 57-A of the New York State Arts and Cultural Affairs Law and the implementing regulations thereof.

INFORMATION ITEMS

- Audits Update
- Compliance Update

Mr. Chris A. Telano
Ms. Catherine Patsos

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT



MINUTES

AUDIT COMMITTEE

MEETING DATE: February 7, 2018

TIME: 11:00 A.M.

COMMITTEE MEMBERS

Emily Youssouf, Committee Chair

Mitchell Katz, MD

Josephine Bolus, RN

Barbara A. Lowe, RN

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

James Linhart, Deputy Corporate Comptroller

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

Rosemarie Thomas, Assistant Director, Office of Internal Audits

Carlotta Duran, Assistant Director, Office of Internal Audits

Frank Zanghi, Audit Manager, Office of Internal Audits

Sonja Aborisade, Audit Manager, Office of Internal Audits

Gillian Smith, Audit Manager, Office of Internal Audits

Melissa Addonisio, Audit Manager, Office of Internal Audits

Armel Sejour, Senior Auditor, Office of Internal Audits

Jean Saint-Preux, Staff Auditor II, Office of Internal Audits

Erica Nairne-Hamilton, Staff Auditor II, Office of Internal Audits

Roshney Kaur, Staff Auditor, Office of Internal Audits

Robert Hogan, Staff Auditor, Office of Internal Audits

Jessica Fortes, Staff Auditor, Office of Internal Audits

Pantelis Papadopoulos, Staff Auditor, Office of Internal Audits

Jose Santiago, Controller, MetroPlus

L. R. Tulloch, Senior Director, Office of Facilities Development

Anthony Saul, Chief Financial Officer, H + H/Kings

Glenford Hall, Assistant Director, H + H/Kings

OTHER ATTENDEES

PAGNY: Anthony Mirdita, Chief Financial Officer

**FEBRUARY 7, 2018
AUDIT COMMITTEE MINUTES
MEETING**

The meeting of the Audit Committee was called to order at 11:05 A.M. by Ms. Emily Youssouf, Audit Committee Chair.

The minutes of the Audit Committee meeting held on January 11, 2017 were presented to the Committee for approval. A motion was made and duly seconded, the Committee unanimously adopted the minutes.

An additional motion was made and seconded to hold an Executive Session of the Audit Committee to discuss risk assessment to the System.

Ms. Youssouf directed the meeting to Mr. P.V. Anantharam, Corporate Chief Financial Officer to introduce a resolution for KPMG.

Mr. Anantharam presented the Resolution as follows:

“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.”

This contract was originally initiated in April 2014. It was for \$3.4 million with a 10 percent contingency for items that would normally come about as they relate to regular audit work. There is a document that passed the resolution that talks about how the contingency amounts has been used over the past three years, to the tune of about \$150,000 a year for a variety of services relating to new pronouncements. We also had to do reviews of Gotham, the new Federally Qualified Health Center (FQHC) that was set up and also the Accountable Care Organization (ACO) that was created for the Medicare program.

One item that had not been considered at the time that we had approved the resolution was the need for KPMG to conduct an audit of the Medicaid program we currently seek federal reimbursement for.

In 2007, the federal government through the Centers of Medicare & Medicaid Services (CMS) came to our facilities, and they reviewed the facility work in 2010 and suggested that we might not be claiming appropriately based on the cost allocation that we would use for Medicaid eligibility work that our Hospital Care Investigators (HCI) at the front door do. We, of course, protested and argued that all of our work was appropriate. They had indicated that they might drop the reimbursement to six percent of the total that we had claims for. In agreement with them, we decided that we would

engage an auditor to verify our claims, and as such, we used KPMG for that purpose for a cost of about \$250,000. The audit was completed last year, and I am glad to say that the audit verified all of our claims appropriately, and CMS has since reviewed the audit and have accepted that audit. We are still receiving resources, and our revenues back from them to the tune of around \$77 million that has been outstanding from April through September of 2015, and we are looking forward to a reconciliation of that.

Ms. Youssouf stated that it seems like a good return on the \$250,000. Then she asked if there are any questions regarding the resolution.

Ms. Youssouf then read a statement to the Committee provided by KPMG. "January 22nd, 2018, the Department of Justice and the Security & Exchange Commission (SEC) announced that KPMG personnel were subjects of a criminal indictment civil administrative proceeding related to improper disclosure of confidential nonpublic information regarding the Public Company Accounting Oversight Board (PCAOB) inspection program. PCAOB, as an independent oversight board, established its auditing and related professional practice standards for registered public accounting firms. After discovering that a former employee of the PCAOB had joined KPMG and received advanced warnings of engagements to be inspected by the PCAOB, KPMG immediately self-disclosed this to the PCAOB. The employee was since terminated. KPMG reorganized their reporting structure of that inspection group to ensure internal independence."

Ms. Youssouf stated that KPMG contacted us immediately, both the Chief Financial Officer (CFO) and me as the Chair of the Audit Committee, to informed us that the audit team from KPMG that H + H and all government entities is an entirely separate division from the inspection group which KPMG, the one that received the indictment, works exclusively with public companies. I just wanted to disclose that we are assured by KPMG that the situation discovered does not have any conflict or possible ramifications to the nonprofit and to the healthcare division. They have made similar calls to all governmental agencies that use them.

Ms. Youssouf asked for a motion to approve. The Committee unanimously approved the resolution to be presented at the February 22, 2018 Board meeting.

Ms. Youssouf then turn the meeting over to Mr. Telano for an Audits Update.

Mr. Telano saluted everyone and stated that I just wanted to advise the Committee of a new program Internal Audits rolled out to educate individuals throughout the system about the importance of internal controls and the internal audit function. The focus of the program was to define internal control and advise how it can be applied to everyday life, both professionally and personally. We have visited the following facilities:

- Woodhull Leadership Meeting
- One City Health Management Meeting
- Chief Nursing Officers Executive Leadership Meeting

- Coney Island Leadership Meeting
- Metropolitan Town Hall Meetings

It should be noted that at Metropolitan we had four different meetings.

Audits done by regulatory agencies

1. Implementation of the Electronic Medical Record System (Epic) at NYC Health + Hospitals/Elmhurst - NYC Office of the Comptroller

The audit started in September 2016 and the final report was issued last week, January 31, 2018. The scope of the audit was very detailed. In the report, they write that the Elmhurst Hospital Center’s EPIC EMR is generally performing as designed and planned. There was only one audit finding noted and the issue referred to is that the Help Desk took longer than the standards established.

The response, submitted by Dr. Katz on January 25, 2018, stated agreement with the finding and the recommendation to take appropriate steps to reduce the wait time.

2. Nurses’ Qualifications – Office of the State Comptroller

This audit started in May of 2017. They had completed their field work and we had an exit conference on 10/31/17 to discuss the audit findings. The following issues were discussed:

1. Lack of background information and fingerprinting for nurses hired through temporary agencies.
2. Missing employment documents, such as I-9 forms, evaluations and background checks in the human resources files of nurses hired at the five facilities reviewed.
3. Inconsistencies in the titles and salaries of the nurses employed by At Home Healthcare.

As of today, we are still waiting on the issuance of the final draft report, at which time we will be required to issue a response to their findings.

3. Controls Over Equipment – Office of the State Comptroller

This audit began in December. They explained that this audit is of all equipment indicated in our financial statements. They went to Bellevue, and since then they have gone to the Robert Clemente Clinic, East New York and Elmhurst. They are planning on visiting numerous other sites in which they are verifying the physical existence of different equipment.

Completed Internal Audits

1. Outpatient Billing and Collections – Elmhurst (Final Report Issued 12/8/17)

Mr. Telano asked for representatives to approach the table and introduce themselves. They did as follows: Israel Rocha, Chief Executive Officer; David Guzman, Chief Financial Officer; Jeanne Wasserman, Sr. Director of Integration and Interoperability; David Buggie, EPIC GO Support.

Mr. Telano stated that he will go through the findings and then you can respond to them. The findings were as follow:

- a) Because the bad debt report produced by Soarian is inaccurate, corporate finance conducts a reconciliation to confirm that the general ledger entry is correct. The total for fiscal year '17 bad debt was \$11 million or 9% of total outpatient revenue.
- b) The collection effort for self-pay outpatient claims consisted of billing statements for four dunning cycles and then a collection letter sent out automatically by the same Sorian system. No collection agency or other human intervention is utilized.
- c) The hiring of an outside firm PhyCare in October 2015 to provide services to reduce coding backlogs has not been effective. We noted that as of May 8th, there are still approximately 15,000 emergency department un-coded visits dating back about three months.

Mrs. Bolus asked how much did it costs us?

Mr. Anantharam reported that they are paid on a piece basis on the amount of coding that they do. I do not have the exact numbers, but it was about \$1.50 or something along these lines.

Mr. Lowe asked did this effect our value-based data that goes to CMS?

Mr. Anantharam answered no, this was because there was so much backlog in our coding opportunities and since we didn't have enough coders, we decided that we would use PhyCare, who already does the coding for the Faculty Practice Plan (FPP) work, to do the coding for all the backlogs.

Mrs. Bolus asked if we have hired more people or more coders?

Mr. Anantharam answered that we are in the process of figuring out with Huron the number that we actually need.

Dr. Katz stated that consistent with the direction of this Board and what makes sense for an organization, why wouldn't we have high quality coders. We need coders who live in Elmhurst, who work in that community to see that the better you code, the more money you bring in, and the more money you bring in, the more nurses and doctors and social workers and pharmacists you hire. It involves sending people sometimes to school. These are not unusual problems of public systems, it has to be fixed for Health + Hospitals to have a successful future.

Ms. Youssouf asked why are you using a consultant to figure out what the answer is?

Mr. Anantharam answered that Huron is currently in the process of redoing our entire revenue cycle, and assessing how many coders we need will be part of the entire staffing structure. Dr. Katz has charged Ms. McClusky from Post Acute Care with looking at how we can actually train people in-house and recruit them to try to build a cadre of people that can step up to be coders. We are working in earnest and looking at all kinds of things that can allow us to do those kinds of things.

Dr. Katz commented that the Huron contract is actually one that Health + Hospitals needed because, for whatever reason, we never developed the proficiency on billing. It's not forever and their job is not to be our biller, but they are a leading industry group on how to bill. They are teaching us at every level what is the right process, because otherwise we would have to invent it. It is a smart and a good use of consultants. We can learn how do to it or we can ask an industry leader to

come and show how you do it and then leave. That is very much what the contract is. Mr. Anantharam is committed. He has a revenue cycle dashboard that I watch, and he has targets he has to hit and people to be hired and billing that has to occur and then Huron has to go.

Ms. Youssouf commented as long as Huron does not get extended a number of times.

Mr. Telano continued onto the other issue. This is similar to what the New York City Comptroller's Board had revealed, that Soarian issues reported to the enterprise service desk were taking an excessive period of time to resolve.

Ms. Youssouf requested that Mr. Anantharam talk more about the transition, when that is going to happen out of Soarian because that's the biggest issue that you have inherited.

Mr. Anantharam stated that Kevin Lynch our Chief Information Officer (CIO), is working in earnest to get EPIC up and running as quickly as possible, and we are not investing anymore resources in expanding the implementation of Soarian or any other Legacy products. We are expecting that a lot of these issues will go away when the implementation gets into place. In the meantime, we are looking at some of the issues that are of concern between EPIC and Soarian and working through them to try and figure out how to minimize the number of open visits and the like.

Mr. Rocha added that one of the things that we will do very carefully in the planning is to make sure that we get the smallest amount of revenue interruption that we have seen before. Industrywide across the country, when you implement a new financial system, there is always a challenge in making sure that you don't lose billable revenue during that time because systems often have some glitches as you are transferring over. We have some lessons learned through Soarian, as you can see from the audit, that there are opportunities for improvement. Working with Mr. Anantharam, our team and Mr. Lynch's entire team is making sure we minimize that as much as possible so that we can make sure that we get every precious resource that we can from revenue for our system.

Ms. Youssouf asked that since this is revenue and IT, where does the buck stop?

Mr. Anantharam responded that because it is going to be an integrated system, we are now in the process of doing the build of EPIC on the revenue systems. They have already gone through a variety of business users to understand how we do business here. The first integration of the build is in February, and that will allow us to confirm that all of the specs that were laid out are appropriate. While we have been building the specs in the different stations, what we need to confirm is that those specs for station one actually apply well to station four, so it is an end to end review of that process. We will know soon, if it's not to our liking, we will go back, fix what's wrong with it and the entire IT team is working on that.

Mr. Rocha reported that at the facility level, both our CIO and CFO work very closely on it. Because there is an alignment in the transfer of data from the clinical side of the EPIC into the financial components of EPIC. That feed is where trouble can happen, so it actually takes an integrated team. Mr. Lynch has been already sort of working with finance very closely on how that will be administered, but unfortunately one will be responsible which unfortunately is EPIC because

that is the software, but it does require the alignment of our CIO, CMO and our CFO to work in alignment to make sure that the processes are flowing over and we are not losing anything in that transfer.

Mr. Anantharam said that to reiterate and respond, the business committees and the councils that have been created for this EPIC build includes all the users across the system. It goes down to patient registration to the billing staff at all of the facilities.

2. *Scheduled II Controlled Substances (Narcotics) – Sea View (Final Report Issued 1/15/18)*

Mr. Telano asked for the representatives to approach the table and introduce themselves. They did as follows:

Maureen McClusky, Senior Vice President of Acute Care; Angelo Mascia, Chief Executive Officer; Patrick O'Toole, Pharmacy Director.

Although they have maintained a manual inventory system, our unannounced inventory count found no discrepancies, which is a good thing. However we did note that the pharmacy department needs to improve their documentation. First, we found that order forms used by the patient units to request narcotics from the pharmacy department are not properly completed. Some were missing the patient's name, some missing the authorized signature from the ordering nurse and we found two in which both instances were lacking.

I just wanted to note that the Internal Audit staff verified that there were active doctor orders in place to support the request for those 30 incomplete prescriptions. So even though there was information missing on those forms, they were for legitimate orders.

Mrs. Bolus asked if the order form is from the 1980 and if they corrected it? To which Mr. Telano answered yes.

Dr. Katz stated that I would be interested to hear more about that in the sense that usually pharmacies are pretty strict. If you don't have this, they just send it back. So obviously this is not a malfeasance. The patients were ordered the medicine, so I am not worried, but, I am surprised on the process.

Mr. O'Toole said that those are requests by nurses for sub-stocks. Sub-stocks ordered on the HHC form from 1980, it's a big book. It's an antiquated system, we are still in a paper system at Sea View. The nurses order a sub-stock in a pink book, based on a physician's order that we have already inside the system, and then we dispense as such.

Dr. Katz commented that you already have a difference, it's like they're parallel systems and one of them is accurate and one of them is incomplete.

Mr. O'Toole demonstrated the book used, it's in the book that's a duplicate. Nurses will request a sub-stock, put the person's name on top for who it's for and then will sign that they received it from the pharmacist.

Dr. Katz stated I am trying to imagine – so I am the doctor at Sea View. I order my opioid prescription for my patient, do I order that on paper?

Mr. O'Toole said that that is ordered on an interim form or computerized renewal. It's uploaded into our system, computerized orders, inside our QS1 system. The nurses are requesting a sub-stock to be kept on the floor, since we are not dispensing it to the patient's name. So they have sub-stocks on each floor, we don't have a Pyxis system, we have sub-stock.

Dr. Katz asked how is the sub-stock connected to the doctor's prescription?

Mr. O'Toole answered that if you order a prescription for example, Oxycodone, five milligrams, the nurse needs electronic access inside her safe so this way she can dispense the medications. All other medications are individualized. Sub-stocks for controlled substance are not. There are sub-stocks on the floor that is the difference.

Dr. Katz stated that we are all understanding these patients all had appropriate orders, but what would keep in the current system, so I write a five milligrams. Would that sub-stock go to the ward?

Mr. O'Toole responded that sub-stock will go to the floor, but we are double-checking our computer systems too, so we know what the patients are going to be receiving anyway. We also have a rotating log on what the floor is utilizing, so there is a couple of checks and balances there. The recommendations that the auditors made will assist us with possible diversion.

Dr. Katz commented that I think it's good for audits to uncover problems, but audit is not pharmacists, audit is not nurses, audit is not physicians or administrators, you are. I want you to problem solve in what you think is the right way and what is considered, it does not seem like this is the modern way.

Mr. O'Toole stated that it's not – but it's the way we have been using for the last 38 years at our facility.

Dr. Katz asked could we be looking at a different model going forward -- if so, what could that be?

Mr. O'Toole answered that with different models comes money and a Pyxis system would be ideal for controlled substances.

Dr. Katz commented that that in and of itself is not a good reason not to move forward with more modern technology. It does seem like, in general from a high level view, that the pink paper system does not seem like the right ultimate solution. That is not a criticism of what we are currently doing. I could look to Ms. McClusky for suggesting on what might be other alternatives that we could do and then it becomes a Board decision about the spending on it.

Ms. Youssouf asked if there are other institutions within our system that use the pink form?

Mr. O'Toole responded that they are using a form – this is the virtual form from H+H from 1980.

Ms. McClusky added that we could have a sub-stock of 500 Oxycodone in a drawer sitting in the vault on the nursing unit.

Mr. O'Toole said that we are not going to go that far because I try to keep everything nice and tight where I am so we do not try to have an opportunity for diversion. But we will have 30 tablets of

Oxycodone, 5 milligrams, on that floor to be given to those patients who have prescriptions for those orders.

Ms. McClusky stated that moving forward, we will have all the narcotics, in blister packs, and barcoded so the patients will receive exactly what they are supposed to be getting in terms of the order. If it is for 5 days, there will be 5 days allocated for that patient. If it is 20 days, it will be 20 pills allocated for that patient.

Dr. Katz said that that sounds safer going forward, and again the system that we are hearing about is a perfect 1980 system. To be clear, this audit did not detect anything wrong, but that does not mean we should not use it as an opportunity to ask ourselves what the best system going forward would be.

Ms. Youssouf stated that I would just urge you to try to make sure, whatever the system is, that it gets implemented.

Mr. Telano continued by stating that the forms used for ordering controlled substances and the Drug Enforcement Administration 222's (DEA) were not issued in order. Once again, we had to research the existence of these forms, and we did find that they all were for legitimate orders and to segue into what we were talking about before, there is an opportunity to have these items ordered electronically through Cardinal at this time.

Mr. O'Toole stated that yes, which we are doing.

Ms. Youssouf asked if this is the case at other facilities? To which Mr. O'Toole answered yes, they are going through CSOS. CSOS is an electronic way of ordering controlled substances, scheduled 2 controlled substances.

Ms. Youssouf asked is that going to be implemented everywhere?

Ms. McClusky answered that they are all doing it now, it is required. We are going to be moving to a new pharmacy mile. They will help us electronically streamline and validate and ensure that prescriptions are being ordered appropriately.

Ms. Youssouf stated okay and asked Mr. Telano to get back to us after you go back and do a check to be sure. As Dr. Katz said, you have not done anything wrong. We are trying to move everything forward and technology compliance.

Mrs. Bolus asked if you have computers in one place and paper on the other part?

Mr. O'Toole responded that we process the physician orders via a computer.

Mr. Mascia added that the doctor still fills out manually, there is no electronic medical record. Then the pharmacy enters these handwritten prescriptions into a system which helps with the billing.

Mr. Telano continued, the last comment we have is that the pharmacy technician, who was responsible for ordering pharmaceutical items, is the only individual with that responsibility, and we recommended that someone be implemented as backup.

Mr. O'Toole stated that we had another backup. The ID password was outdated because it has not been used, after a period of three months, they expired and we have to get an update to the password.

Mrs. Bolus asked what happens if the computers are down?

Mr. O'Toole answered that we have to use a 222 form, which is allowed.

Dr. Katz commented that every organization has to have a paper alternative because computers do go down and patients do not cease being sick when the computers are down.

Mr. Telano stated that that concludes his report.

Ms. Youssouf then directed the meeting to Ms. Patsos for a Compliance Update.

Ms. Patsos saluted everyone and introduced herself as Catherine Patsos, Acting Chief Corporate Compliance Officer. She stated that she would like to start off by reporting that OP 50-1 which is the Corporate Compliance and Ethics Program was formally promulgated by the system on January 5th and distributed on internal website and the public website, as well as everyone received a memorandum and PowerPoint presentation training them, educating them on the OP 50-1.

Each year we have to certify under the Social Services Law 363 d and part 521 of the Social Services regulations that we have implemented an effective compliance program, and we also must certify, under the Deficit Reduction Act, that we have established and disseminated policies and procedures regarding the False Claims Act and state laws and fraud, waste and abuse policies and procedures. Both of these certifications were completed in December 2017.

The Office of Corporate Compliance does monitor monthly for exclusions and disciplinary actions in both the federal and state databases. In addition to those databases, we also screen against the Office of Foreign Asset Control and the Death Master File and the National Plan and Provider Enumeration System Screening. There were no excluded providers or disciplined providers since we last reported.

During the fourth quarter, there were a total of thirty-three privacy incidents that were reported. Eleven of them were violations of our HIPAA policies and procedures, seven were determined to be unsubstantiated, seven were not violations of our policies and procedures and eight are still under investigation. Of the eleven that we determined to be violations, seven were determined to be breaches. Some of them have to do with simply giving the patient information to the wrong patient, and in which case we attempted to retrieve that information from them.

Some of the other ones involve, for example, at Bellevue in October 2017, there was an incident which involved a physician, who, during the course of doing rounds, had left patient records in one of the pediatric patient's rooms. The mother of one of the patients there thought that those records belonged to her child, and took them home. They were returned, but three patient records were found to be missing. As part of the mitigation efforts for that particular incident, we have put in

shredding bins in the department so that physicians and personnel can deposit their rounding papers in shredding bins after their rounds.

At North Central Bronx, there was an incident where a volunteer of New York City Health and Hospitals had left patient records in her car, which was stolen. The car was subsequently returned, but one form of a patient record was missing, the notification was sent out to that patient. All of the notifications to effected individuals were sent out within a 60 day period.

Ms. Youssouf asked if that is normal procedure that a volunteer would have access to confidential documents to take them out of the building?

Ms. Patsos answered that these were not medical records, they were forms for a particular program that they had mostly demographic information on them, which is still considered to be protected health information and she should not have them in her car to begin with.

Dr. Katz stated that no protected information should be in people's cars, but it sounds like it was a community referral.

Ms. Youssouf suggested that that maybe that is something that should be reinforced now.

Ms. Patsos stated that after those incidents, the people involved were provided reinforced training on various policies and procedures that we have and to not remove protected health information from the facilities.

Just to note, there were no inquiries initiated by the office of Civil Rights in the fourth quarter.

There were 96 compliance based reports in the fourth quarter. One of them was a priority A report, which requires immediate attention, 29 were classified as priority B, and 66 as priority C. In the priority A report incident, a mother of a patient sent a letter to various individuals and departments, including the Department of Health's Office of Professional Medical Conduct and Department of Education's Office of Misconduct Enforcement, to Mr. Gordon Campbell, to Mr. William Hicks, Executive Director at Bellevue and the COO at Bellevue, Michael Rawlings. The allegations in her letter pertained to the care and treatment of her son. Specifically, inappropriate treatment and inappropriate prescribing of medications, as well as provider misconduct.

Our office, the Office of Corporate Compliance, referred this matter to Bellevue, and a review of the allegations by Bellevue determined that the care that was provided to the patient was appropriate and that there was no factual basis for the claims that were asserted in the report. We are awaiting a final report being prepared by Bellevue at this time.

There was also a retaliation report by an employee at Queens who claimed that her supervisor was arbitrarily being discriminatory, more specifically in the management department. She claimed that she was unfairly denied a promotion and was required to submit evidence of her vacation plans before being granted leave. Human Resources discovered that there were other individuals in this department who had made similar complaints with regard to this particular supervisor. They sought to have the supervisor removed and she has been removed from the payroll department and placed

into budget, effective February 5th. She no longer has any oversight in payroll at Queens. They have replaced her with a new supervisor.

Ms. Youssouf asked if she was removed from that position but there is somebody there now who took over her?

Ms. Patsos responded yes.

We have been conducting a review of HIPAA privacy and procedures for the system, although many of these policies are already embedded in existing procedures. We have determined that some of them do warrant updating and perhaps should have their own separate policies, those being ones regarding breach response and notification, the minimum necessary use and disclosure of protected health information, and business associate agreement procedures.

In December the Office of Corporate Compliance took over the privacy related functions and duties from the facility privacy officers so now all such functions and duties are centralized within our office, which has made them much more efficient and streamlined.

In addition, there are other policies and procedures related to compliance that have gone through final legal review and will be ready by the end of this month. We expect, for finalization and for the signature Operating Procedures regarding, the Civil Monetary Penalties Law, Compliance with False Claims Act, Fraud, Waste and Abuse Policies, and the Emergency Medical Treatment and Active Labor Act, (EMTALA).

There is an update on the DSRIP compliance activities. Every year we make sure that the OneCity Health partners attest to their compliance with the Social Services Law and Deficit Reduction Act. We are sending out the attestations this week and we will be processing those results.

It was reported in the December report that OneCity Health had sent out a request for proposals for an independent auditor to audit the internal controls of OneCity Health, specifically the partner selection, the partner payment, the funds flow, the partner portal through which information is shared, and the reporting process to the State. We have received only two proposals and those are currently being evaluated.

As reported in December, the HHC ACO submitted an application to the State to be an all payer ACO. That application is still pending. The draft documents submitted with the application, the ACO Compliance Plan, the Standards of Conduct and the Training and Education Materials, have subsequently been revised and disseminated to the HHC ACO Board of Directors.

That concludes my report.

(The executive session was held.)

There being no other business, the meeting was adjourned at 12:20 P.M.

Submitted by,
Emily Youssouf
Audit Committee Chair

RESOLUTION

Authorizing New York City Health and Hospitals Corporation (the “System”) to execute an agreement with Grant Thornton, LLP (“Grant Thornton”) to provide auditing services over a four year term at a total cost throughout the term not to exceed \$4,452,225, including a 15% contingency fee for billable services.

WHEREAS, the System issued a request for proposals for the provision of the necessary auditing services which was approved by the Contract Review Committee by its letter dated January 24, 2018; and

WHEREAS, KPMG has been the System’s auditor for more than 30 years; and

WHEREAS, in response to the request for proposals, six audit firms submitted proposals of which KPMG and Grant Thornton were the two highest-rated and both presented before the Selection Committee; and

WHEREAS, the President exercised his authority acting in the best interest of the System to recommend to the System's Audit Committee and its Board of Directors that the System enter into a contract with one of the two firms highest-rated by the Selection Committee, Grant Thornton, on the basis that a new, highly-qualified auditor will provide a fresh perspective on the System's controls and audit; and

WHEREAS, under the proposed agreement, Grant Thornton will provide auditing services for the System for the next four fiscal years; and

WHEREAS, Grant Thornton will:

- Prepare an audit and render an opinion of the annual financial statements for the System and its Component Units, and if necessary, render a management letter addressing any material weaknesses;
- Issue/present a report to the MetroPlus audit committee;
- Review and if necessary, audit MetroPlus’ Regulatory Schedules;
- Certify/Attest reports for 6 Ambulatory Health Care facility reports and 4 Residential Health Care Facility reports;
- Issue annual debt compliance letters in connection with System bonds; and
- Prepare annual Federal Form 990 for Gotham and any NYS Charities filings required;
- Provide 300 hours of tax advisory services;
- Provide professional staff developmental days (6 up to 150 per year) ;
- Provide reports of CPA hours worked for wage index reporting; and
- Provide additional billable services for debt issuance fees, tax advisory services and Governmental Accounting Standards Board implementations; and

WHEREAS, the proposed agreement for Grant Thornton’s services will be managed by the Deputy Corporate Comptroller for the Office of the Corporate Comptroller.

NOW THEREFORE BE IT:

RESOLVED, that New York City Health and Hospitals Corporation be and hereby is authorized to execute an agreement with Grant Thornton to provide auditing services for the System over a term of four years with the total cost of the agreement throughout the term not to exceed \$4,452,225, inclusive of a 15% contingency fee for billable services.

**EXECUTIVE SUMMARY
AUTHORITY TO CONTRACT
WITH GRANT THORNTON, LLP FOR AUDIT SERVICES**

BACKGROUND: The purpose of the proposed agreement is to contract with an independent public accounting firm to perform annual audits of the financial statements for the next four fiscal and calendar years of reporting. This is a requirement of the NYC Health + Hospitals Corporate by-laws as well as the Public Authorities Accountability Act. Also, Federal and State agencies require audit certification/attestation of some of the System's cost reports that are filed. KPMG has been the System's auditor for over 30 years pursuant to a succession of Board authorizations and contracts.

PROCUREMENT: The System issued a Request for Proposals on January 31, 2018. Six proposals were received, evaluated and scored. KPMG and Grant Thornton were the two highest rated proposers and they were invited to present before the Selection Committee. Vendor presentations were held on Friday March 9, 2018. Through this process, the Selection Committee evaluated the proposals and presentations on the basis of the firms' qualifications, staffing levels, and audit team make-up, experience in NY City/State governmental and health care auditing, experience in Federal and NY State reimbursement methodologies and regulations, experience with public bond offerings and related requirements of underwriters and attorneys, understanding of work to be performed, depth of tax consulting, and professional fee. Based on the evaluation criteria, KPMG and Grant Thornton were both determined to be competent to provide the necessary deliverables required by the System.

Pursuant to his authority granted in OP 100-5, the President exercised his authority acting in the best interest of the System to recommend to the System's Audit Committee and its Board of Directors that the System enter into a contract with one of the firms, Grant Thornton, on the basis that a new, highly-qualified auditor will be able to provide a needed fresh perspective on the System's controls and audit. The President took note of the spectrum of opinions from the accounting community regarding the benefit of changing audit firms periodically, considered the particularly long tenure of KPMG with the System, and recognized that Grant Thornton was an RFP finalist with KPMG. The President's view was that a change of audit firms after 30 years will be beneficial to the System.

BUDGET: The cost of the proposed agreement will not exceed \$4,452,225 over the full four year term. This amount includes a 15% contingency for work on related matters. The total amount has been budgeted and signed off by Central Finance.

TERM: The term of the proposed agreement is four years.

Request for Authority to Engage Accounting Firm for Auditing Services

Audit Committee

April 12, 2018



Overview of Procurement Process

- Contract Review Committee approval granted on January 23, 2018, for issuance of a Request for Proposal (RFP) for audit services
- RFP issued January 31, 2018
- Mandatory pre-bidder's conference held on February 8, 2018
- Responses to RFP received from six audit firms February 26, 2018
- First round scoring occurred on March 5, 2018
- Two highest rated firms, Grant Thornton and KPMG, invited for interviews with Selection Committee on March 12, 2018



RFP Evaluation Criteria and Selection Committee Members

Evaluation Criteria

- Qualifications of staff, staffing levels, and audit team make-up
- Experience in NY City/State governmental and health care auditing
- Experience in Federal and NY State reimbursement methodologies and regulations
- Experience with public bond offerings and related requirements of underwriters and attorneys
- Understanding of work to be performed
- Depth of tax consulting
- Fee

Evaluation Committee:

- Linda Dehart, Asst. Vice President
- Olurotimi Diyaolu, Controller – HCF
- Jozef Dubroja, Director Fiscal Affairs
- Barbara Keller, Deputy Counsel
- James Linhart, Deputy Corporate Comptroller
- Jose Santiago, Controller – MetroPlus
- Tatyana Seta, CFO – OneCity Health
- Manuela Brito, CFO – Post Acute Care



Proposals

- Proposed fees ranged of from \$3.3 million to \$11.3 million
- Of the six firms considered, KPMG and Grant Thornton were both determined to be competent to perform the work
- Grant Thornton's fee proposal is marginally lower than KPMG
- Pursuant to OP 100-5, the President is recommending that the System enter into a contract with Grant Thornton on the basis that a new, highly-qualified auditor will be able to provide a needed fresh perspective on the System's controls and audit.



About Grant Thornton

- Ranked 6th largest accounting firm in the metro New York area
- Auditors for The City of New York since 2016, and The Centers for Medicare and Medicaid Services (CMS)
- Over 600 professionals nationally dedicated to healthcare providers
- 1,280 healthcare clients, including 2 public health systems in New York:
 - Westchester County Health Care Corporation
 - Nassau University Medical Center



Grant Thornton Audit Team

- Tami Radinsky, Partner, Northeast Health Care Leader
 - Will serve as Lead Engagement Partner
 - Big Four firm accounting experience
 - Over 17 years of experience in external and internal audits

- Louis Feuerstein, Managing Director, Health Care Industry
 - Will oversee relationship with New York City Health + Hospitals
 - Prior partner with Ernst & Young
 - Over 35 years experience in health care
 - Managed the Ernst & Young's healthcare consulting practice in New York



Grant Thornton Audit Team (continued)

- Frank Kurre, Partner, Northeast Regional Leader
 - Managing partner for all services provided by Grant Thornton to clients in eight states

- Dana Wilson, Partner, Insurance Industry Audit Practice Leader
 - Serve as engagement audit partner for all insurance related deliverables

- Daniel Romano, National Managing Partner, Not-for-Profit Tax Leader
 - Provide tax consulting and compliance services



RESOLUTION

Approving the designation of Sheetal Sood, Senior Executive Compliance Officer, as the New York City Health + Hospitals (the “System”) Record Management Officer (“RMO”), as that term is defined under New York State Education Department regulations found at 8 NYCRR § 185.1(a), to coordinate the development of and oversee the System’s records management program in accordance with the requirements set forth under Article 57-A of the New York State Arts and Cultural Affairs Law and the implementing regulations thereof.

WHEREAS, § 57.19 of Article 57-A of the New York State Arts and Cultural Affairs Law (Local Government Records Law), and its implementing regulation found at 8 NYCRR § 185.2(a)(1), require the governing body of each local government to designate a RMO who will be responsible for developing and coordinating the local government’s records management program; and

WHEREAS, the System, as a public benefit corporation created under the laws of the State of New York, meets the definition of a local government under New York State Arts and Cultural Affairs Law § 57.17(1); and

WHEREAS, William Gurin, former Deputy Corporate Compliance Officer within the System’s Office of Corporate Compliance (“OCC”) and former RMO of the System, left the System on March 9, 2018; and

WHEREAS, Mr. Gurin’s departure from the System has created a vacancy in the RMO position; and

WHEREAS, New York State Education Department regulation 8 NYCRR § 185.2(b)(1) requires that whenever a vacancy shall occur in the position of the RMO, a replacement shall be designated within sixty (60) days; and

WHEREAS, Ms. Sood currently holds the functional title of Senior Executive Compliance Officer within the System’s OCC, and is charged with senior compliance oversight of the System’s HIPAA privacy and security compliance functions; and

WHEREAS, the Acting Chief Corporate Compliance Officer within the OCC, with the President and Chief Executive Officer’s concurrence, has selected Ms. Sood to be designated as the System’s RMO; and

WHEREAS, the OCC now respectfully requests that the Audit Committee of the NYC Health + Hospitals Board of Directors (“Audit Committee”) designate Ms. Sood as the System’s RMO; and

WHEREAS, we believe that Ms. Sood is qualified to carry out the functions of the RMO as set forth under applicable law.

NOW, THEREFORE, be it

RESOLVED, that the Audit Committee designates Sheetal Sood, Senior Executive Compliance Officer within the OCC, as the System's RMO, as that term is defined under New York State Education Department regulations found at 8 NYCRR § 185.1(a).

EXECUTIVE SUMMARY
For the Resolution Appointing Records Management Officer

Pursuant to New York Arts and Cultural Affairs Law §§ 57.17(1) and 57.19, and their implementing regulation found at 8 NYCRR § 185.2(a)(1), all local government public benefit corporations (“public benefit corporations”), which include NYC Health + Hospitals (the “System”), are required to designate a Records Management Officer (“RMO”) who will be responsible for developing and coordinating the public benefit corporation’s records management program. Section 57.19 of the Arts and Cultural Affairs Law calls for the chief executive official of each public benefit corporation to designate a records management officer, subject to the approval of the public benefit corporation’s governing body.

There currently being a vacancy in the ROM position, Catherine Patsos, Acting Chief Corporate Compliance Officer (“CCO”) of the Office of Corporate Compliance (“OCC”), has selected Sheetal Sood, Senior Executive Compliance Officer (“SECO”) of the OCC, to serve as the System’s RMO. The System’s President and Chief Executive Officer, Mitchell Katz, M.D., has concurred with Ms. Patsos’ selection and has designated Ms. Sood to serve as the System’s RMO.

As SECO, Ms. Sood currently assists Ms. Patsos, as the System’s Corporate Privacy and Security Officer (“CPSO”), on System-wide privacy and security matters, and provides senior executive compliance oversight of the System’s HIPAA Privacy/Security Program. In this role, Ms. Sood is responsible for information governance, risk and compliance activities related to HIPAA privacy and data security, including conducting annual risk assessments; reviewing and responding to potential compliance issues and complaints; conducting investigations; performing focused reviews; ensuring completion of compliance training for affected employees; and reporting HIPAA compliance activities to the CCO. Ms. Sood also works closely with the Health Information Management (“HIM”) teams throughout the System, and the Office of Legal Affairs (“OLA”) in performing her duties.

Prior to joining NYC Health + Hospitals, Ms. Sood served as the Chief Privacy Officer and Director of IT Audits for the New York City Housing Authority where she was responsible for setting the information privacy strategy including confidentiality of records, and leading the organization-wide data loss protection program. Additionally, she was the point person for all information technology audits for the organization.

In the past, Ms. Sood has worked in various industries, including technology start-ups and Bear Stearns, in Information Security roles in senior leadership capacities. She has also worked with other New York City agencies such as the New York City Department of Transportation and the New York City Office of Emergency Management in senior IT operational roles.

As an information governance executive for more than twenty years, Ms. Sood has extensive experience in information security, audit and investigation of physical and information systems and networks, business continuity, security awareness education, IT operations, risk management and data protection and privacy.

Ms. Sood holds a Bachelor of Science degree in Electronics Engineering. Additionally, she is certified in information security (GSEC, CISSP), risk management (CRISC), information systems audit (CISA), privacy (CIPP/US), and health care compliance (CHC). She also holds numerous other technology product-specific certifications.

Based on Ms. Sood's qualifications provided hereinabove, she is well qualified to carry out the functions of the RMO as set forth under applicable law. With the approval by the Audit Committee of the NYC Health + Hospitals Board of Directors and the subsequent approval by the NYC Health + Hospitals Board of Directors on April 26, 2018, Ms. Sood will be officially designated to serve as the System's RMO.



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I. Monitoring Excluded Providers

Overview of Regulatory Requirements

1) 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.”¹ 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, NYC Health + Hospitals (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.”²

Responsibilities of the System for Sanction List Screening

2) To adhere to these regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General (“OMIG”)³ and the U.S. Department of Health and Human Services Office of Inspector General (“OIG”), each month the Office of Corporate Compliance (“OCC”) reviews the exclusion status of the System’s workforce members, vendors, and New York State Department of Health (“DOH”) Delivery System Reform Incentive Payment (“DSRIP”) Program Partners.

Office of Foreign Asset Control (“OFAC”) Screening

3) 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

¹ 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).

² 42 CFR § 424.516 (a) (3); *see* 42 CFR § 424.535(a) (2) (regarding the Centers 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 the U.S. Department of Health and Human Services’ right to exclude a person or entity for failing to meet the obligations).

³ *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)).

against the databases of the United States Department of Treasury Office of Foreign Asset Control (“OFAC”).⁴

Exclusion and Sanction Screening Report January 1, 2018 through March 31, 2018

4) In the First Quarter of 2018, there was one suspended provider identified through the OCC’s monthly sanction screening. On January 31, 2018, OCC was informed that a System employed registered nurse (“RN”) had his RN and LPN licenses suspended, effective December 5, 2017. This nurse worked in the Behavioral Health Department at NYC Health + Hospitals/Woodhull (“Woodhull”). On February 1, 2018, the OCC and Woodhull’s Human Resources Department held a meeting with the nurse, at which time he was placed on inactive status, without pay. Because the nurse furnished services in the Behavioral Health Department of Woodhull while his licenses were suspended, on March 30, 2018, the OCC submitted a letter to the OMIG regarding the identification of a potential overpayment for payments received by Woodhull for such services. The OCC also sent a letter on April 4, 2018 to National Government Services (“NGS”), the Medicare Administrative Contractor, regarding this matter, and requested guidance as to whether a Medicare overpayment may have been made and, if so, how to calculate such overpayment. The OCC will continue to follow-up on this matter.

Death Master File and National Plan and Provider Enumeration System Screening

5) The Centers for Medicaid and Medicare Services’ (“CMS”) regulations⁵ and the contractual provisions found in managed care organization (“MCO”) provider agreements⁶ both require screening of the System’s 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

⁴ 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.

⁵ 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>.

⁶ 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)”).



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Security Administration Death Master File (“DMF”) and the National Plan and Provider Enumeration System (“NPPES”), respectively.

6) 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 in the First Quarter of 2018.

II Privacy Incidents and Related Reports – First Quarter Reports

Reportable Privacy Incidents for the First Quarter of Calendar Year 2018 (January 1, 2018 – March 31, 2018 – hereinafter “1st Quarter”)

7) During the period of January 1, 2018 through March 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, eighteen (18) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures (“OP”), specifically OP No. 240-15 HIPAA Privacy Safeguards Policy, and OP No. 240-28 HIPAA Policy on Uses and Disclosures for Treatment, Payment and Healthcare Operations; eleven (11) were determined to be unsubstantiated; two (2) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures; and two (2) are still under investigation. Of the eighteen (18) incidents confirmed as violations, ten (10) were determined to be breaches.

Breach Defined

8) 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.⁷

9) 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

⁷ See 45 CFR § 164.402.

risk assessment of key risk factors, that there is a low probability that the PHI has been compromised.⁸

Factors Considered When Determining Whether a Breach Has Occurred

10) 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:⁹

- 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 1st Quarter of 2018

11) As stated above, there were ten (10) reportable breaches in the 1st Quarter of 2018. Below is a summary of those breaches:

- **NYC Health + Hospitals/Lincoln – January 2018**

Incident: This incident was discovered on January 17, 2018, and occurred when a follow-up appointment referral form of one patient was given to that patient and another patient. As a result, both patients showed up for the same appointment.

Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the nature and extent of the PHI involved, the description of the unauthorized individual who obtained the PHI, and confirmation that PHI was acquired contributed to

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

⁹ See 45 CFR § 164.402(2)(i-iv).



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the determination that there existed a greater than low probability that the PHI had been compromised. Therefore, notification was sent to the affected individuals on February 20, 2018.

Mitigation: The entire department where this incident occurred was retrained on HIPAA security and privacy control procedures, and staff has been reminded to double-check the patient contact information before disclosing PHI.

- **NYC Health + Hospitals/Lincoln – January 2018**

Incident: The incident was discovered on January 18, 2018, and occurred when a patient was given the discharge papers for another patient. The PHI on the discharge papers included name, medical record number, and discharge information.

Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the nature and extent of the PHI involved, confirmation that PHI was viewed, and the inability to mitigate the risk to the PHI contributed to the determination that there existed a greater than low probability that the PHI had been compromised. Therefore, notification was sent to the affected individual on February 14, 2018.

Mitigation: The employee and the department staff completed comprehensive retraining in HIPAA policies for maintaining the confidentiality of patient information.

- **NYC Health + Hospitals/Harlem – January 2018**

Incident: This incident was brought to our attention on January 22, 2018, and occurred when a resident discussed a patient's sensitive diagnosis information in the presence of two of the patient's visitors. The resident failed to follow proper measures to protect patient privacy by not discussing this information in a private manner.

Breach Determination: All four (4) key factors described previously in paragraph 10 above, contributed to the determination that there existed a greater than low probability that the PHI had been compromised. Therefore, notification was sent to the affected individual on February 20, 2018.

Mitigation: The resident involved in this incident was scheduled for in-service retraining in early March on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information.

- **NYC Health + Hospitals/Lincoln – January 2018**

Incident: This incident was discovered on January 25, 2018, and occurred when a patient mistakenly received medication meant for another patient. The medication container contained PHI such as the patient’s name, address, medical record number, and name of prescribing physician.

Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the nature and extent of the PHI involved, confirmation that PHI was viewed, and the inability to mitigate the risk to the PHI contributed to the determination that there existed a greater than low probability that the PHI had been compromised. Therefore, notifications were sent to the affected individual on March 26, 2018.

Mitigation: In response to this incident, workforce members involved will be retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information. Measures are also being taken to ensure that medication labels are double-checked before giving the medications to the patients.

- **NYC Health + Hospitals/Harlem – January 2018**

Incident: The incident, which was discovered on January 29, 2018, involved a missing unencrypted laptop from an exam room in an Audiology Department at Harlem. Specifically, a Harlem audiologist stepped away from an Audiology Department laptop in a patient examination room for a few minutes. When she returned, the laptop was missing from the room. The theft of this laptop computer was reported to the Harlem Hospital Police and the matter is currently under investigation. The PHI that was stored on the laptop computer included information such as name, medical record number, date of birth, and whether or not a hearing test was passed. This breach involved five hundred ninety-five (595) individuals.



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Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the inability to mitigate the risk to the PHI contributed to the determination that there existed a greater than low probability that the PHI had been compromised. Therefore, notification was sent to the affected individuals on March 30, 2018.

In addition, and in accordance with HIPAA regulations, because the breach involved more than 500 individuals, notification of the breach was made to the Secretary of the U.S. Department of Health and Human Services. Notification was also made to two prominent media outlets, in compliance with HIPAA regulations.

Mitigation: Harlem and the OCC have promptly taken a number of steps in response to this incident. First, Harlem immediately notified local law enforcement of the incident. Second, Harlem is reviewing the physical security precautions currently in place to identify those areas in which security measures require supplementation. Where possible, Harlem plans to install additional security cameras for surveillance. Third, the OCC is reviewing additional security precautions that can be implemented for its portable devices – like the Audiology laptop. Fourth, the OCC is reviewing its security awareness training so as to emphasize to workforce members, the importance of safeguarding PHI. Lastly, to help relieve concerns and restore patient confidence following this incident, NYC Health + Hospitals engaged the services of a risk management vendor, Kroll Information Assurance LLC, to provide identity theft protection including Identity Theft Consultation and Restoration for one year, at no cost, to the affected individuals.

- **NYC Health + Hospitals/Metropolitan– February 2018**

Incident: This incident was discovered on February 6, 2018, and occurred when a nurse discussed a patient’s sensitive health information in the presence of a hospital visitor. The nurse failed to follow proper measures to protect patient privacy by not discussing this information in a private manner. The disclosed PHI included the patient’s sensitive diagnostic information.

Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the unauthorized person to whom the PHI was disclosed and the inability to mitigate the risk to the PHI contributed to the determination that there existed a greater than low



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probability that the PHI had been compromised. Therefore, notification was sent to the affected individual on April 4, 2018.

Mitigation: The nurse involved in this incident is on a pre-hearing suspension without pay, and disciplinary charges have been filed against her.

- **NYC Health + Hospitals/Queens – February 2018**

Incident: This incident was discovered on February 6, 2018, and occurred when a patient's encounter form was mistakenly given to another patient. The PHI on the form included information such as name and medical record number, address, age, medications, and dates of appointments.

Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the nature and extent of the PHI involved and the inability to mitigate the risk to the PHI contributed to the determination that there existed a greater than low probability that the PHI had been compromised. Therefore, notification was sent to the affected individual on April 2, 2018.

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

- **NYC Health + Hospitals/Bellevue – February 2018**

Incident: This incident was discovered on February 12, 2018, and occurred when a patient was mistakenly given another patient's discharge summary papers. The PHI on the form included information such as name and medical record number, address, age, medications, and post-care instructions.

Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the nature and extent of the PHI involved and the inability to mitigate the risk to the PHI contributed to the determination that there existed a greater than low probability that



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the PHI had been compromised. Therefore, notification was sent to the affected individual on April 6, 2018.

Mitigation: Good faith efforts to have the patient return the incorrect discharge papers were not successful. Workforce members involved in the incident will be retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information.

- **NYC Health + Hospitals/Lincoln – February 2018**

Incident: This incident was discovered on February 22, 2018. A patient in the emergency room inquired about waiting times and his place on the waiting list. In response, a triage nurse consulted the patient wait-list report and showed it to the patient, who then proceeded to take a picture of the report. The patient showed the picture to the nurse who asked him to delete the picture from his phone, which he refused to do, and he left the facility. The PHI on the patient wait-list report included patient name, date of birth, and medical record number for seventeen (17) individuals.

Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the inability to mitigate the risk to the PHI contributed to the determination that there existed a greater than low probability that the PHI had been compromised. Therefore, notification was sent to the affected individuals between March 29 and April 2, 2018.

Mitigation: Workforce members will be retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information. They have also been advised to move the patient wait-list reports into secure areas where they cannot be inappropriately accessed.

- **NYC Health + Hospitals/Elmhurst– March 2018**

Incident: This incident was discovered on March 8, 2018, and occurred when a workforce member inappropriately accessed a patient’s medical record without the patient’s consent.



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Breach Determination: Of the four (4) key factors described previously in paragraph 10 above, the unauthorized person to whom the PHI was disclosed, and confirmation that PHI was accessed contributed to the determination that there existed a greater than low probability that the PHI had been compromised. Therefore, notification was sent to the affected individual on April 4, 2018.

Mitigation: In response to the incident, a labor action is being filed and disciplinary charges are being brought against the concerned workforce member.

Office of Civil Rights (“OCR”) Inquiries Regarding Potential and/or Determined Privacy Incidents During the 1st Quarter of 2018

12) There were no inquiries initiated by the OCR in the 1st Quarter of 2018.

III Compliance Reports – 1st Quarter Reports

Summary of 1st Quarter Reports

13) For the 1st Quarter of CY2018, there were ninety-one (91) compliance reports of which one (1) (1.1%) was classified as a Priority “A”;¹⁰ thirty-two (32) (35.2%) were classified as Priority “B”; and fifty-eight (58) (63.7%) were classified as Priority “C” reports. For purposes here, the term “reports” means compliance-based inquiries and compliance-based complaints. The ninety-one (91) reports were received from the below-listed sources:

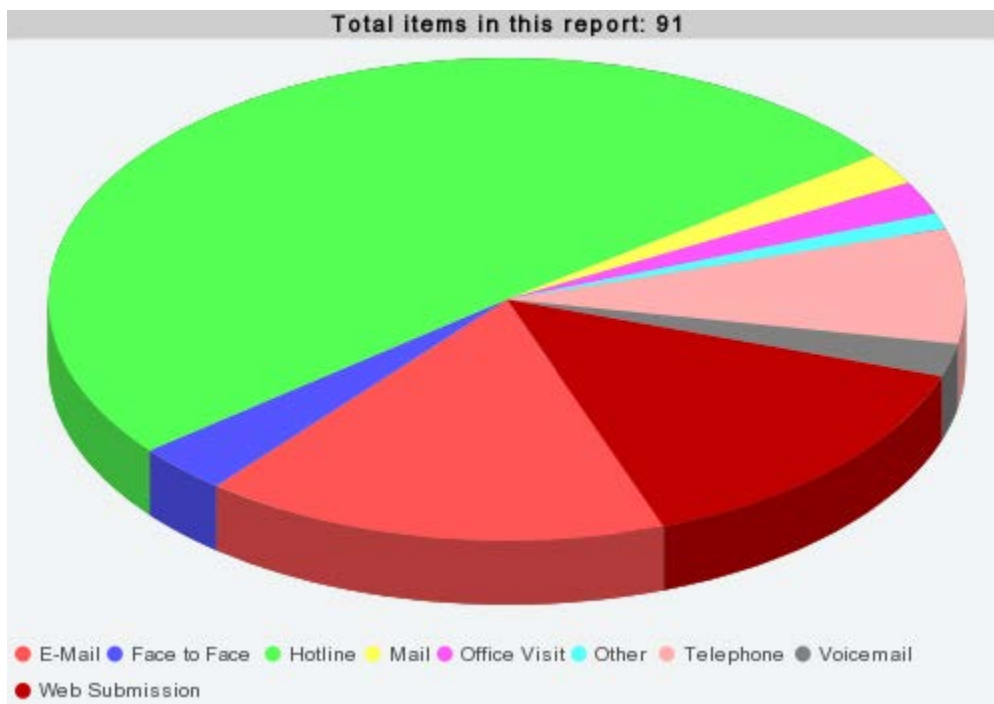
a. PRIMARY ALLEGATION SOURCES

SOURCE

| | Total | Frequency (Percentage) |
|--|-------|------------------------|
|--|-------|------------------------|

¹⁰ 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.

| | | |
|----------------|-----------|------------|
| E-Mail | 15 | 16.5 |
| Face to Face | 3 | 3.3 |
| Hotline | 46 | 50.5 |
| Mail | 2 | 2.2 |
| Office Visit | 2 | 2.2 |
| Other | 1 | 1.1 |
| Telephone | 7 | 7.7 |
| Voicemail | 2 | 2.2 |
| Web Submission | 13 | 14.3 |
| Total | 91 | 100 |

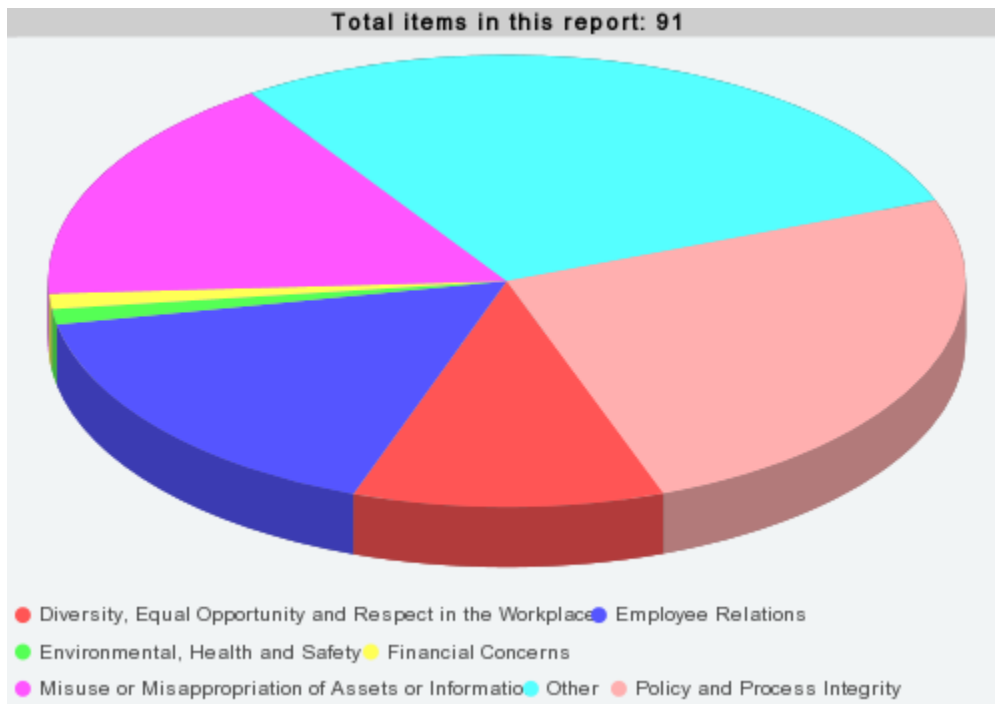


b. PRIMARY ALLEGATION CLASS

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

PRIMARY ALLEGATION CLASS

| | Total | Frequency (Percentage) |
|---|--------------|-------------------------------|
| Diversity, Equal Opportunity and Respect in the Workplace | 10 | 11 |
| Employee Relations | 15 | 16.5 |
| Environmental, Health and Safety | 1 | 1.1 |
| Financial Concerns | 1 | 1.1 |
| Misuse or Misappropriation of Assets or Information | 15 | 16.5 |
| Other | 26 | 28.6 |
| Policy and Process Integrity | 23 | 25.3 |
| Total | 91 | 100 |



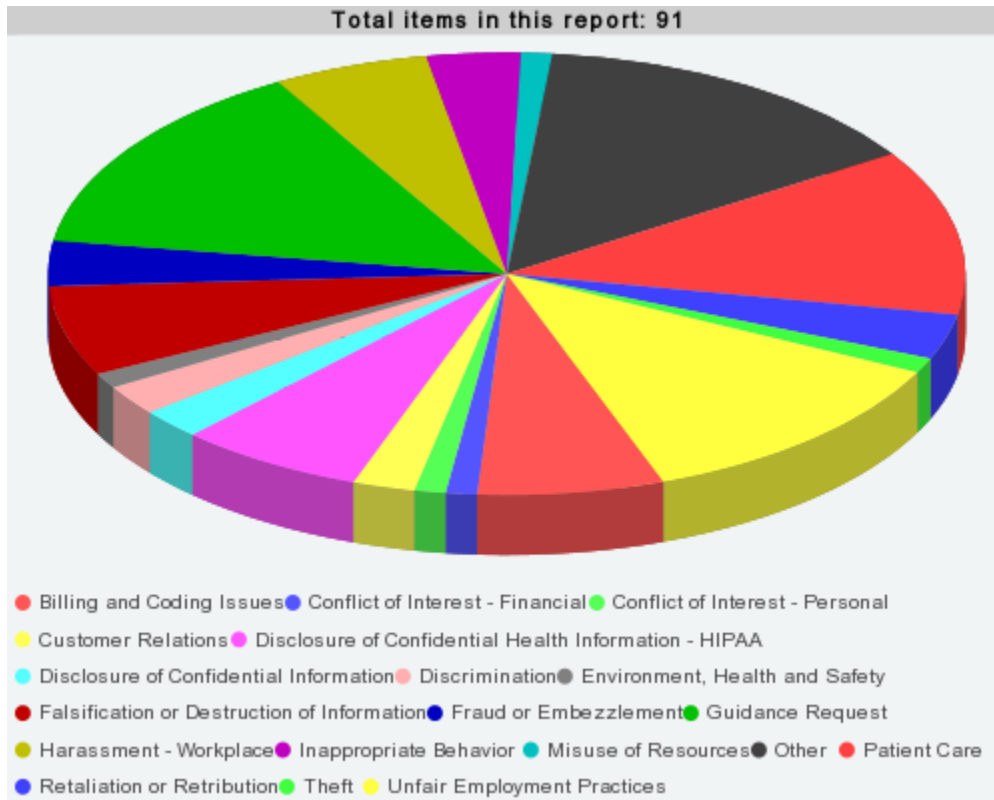


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c. PRIMARY ALLEGATION TYPE

PRIMARY ALLEGATION TYPE

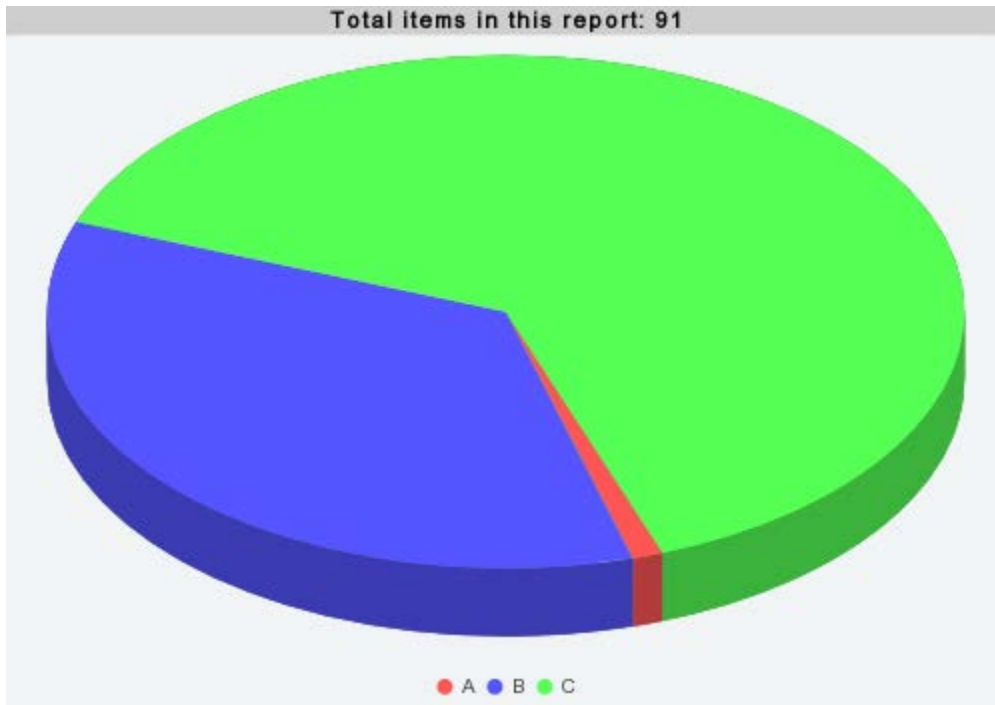
| | Total | Frequency (Percentage) |
|---|--------------|-------------------------------|
| Billing and Coding Issues | 6 | 6.6 |
| Conflict of Interest - Financial | 1 | 1.1 |
| Conflict of Interest - Personal | 1 | 1.1 |
| Customer Relations | 2 | 2.2 |
| Disclosure of Confidential Health Information - HIPAA | 6 | 6.6 |
| Disclosure of Confidential Information | 2 | 2.2 |
| Discrimination | 2 | 2.2 |
| Environment, Health and Safety | 1 | 1.1 |
| Falsification or Destruction of Information | 6 | 6.6 |
| Fraud or Embezzlement | 3 | 3.3 |
| Guidance Request | 13 | 14.3 |
| Harassment - Workplace | 5 | 5.5 |
| Inappropriate Behavior | 3 | 3.3 |
| Misuse of Resources | 1 | 1.1 |
| Other | 13 | 14.3 |
| Patient Care | 11 | 12.1 |
| Retaliation or Retribution | 3 | 3.3 |
| Theft | 1 | 1.1 |
| Unfair Employment Practices | 11 | 12.1 |
| Total | 91 | 100 |



d. PRIORITY CLASSIFICATION

PRIORITY

| | Total | Frequency (Percentage) |
|--------------|-----------|------------------------|
| A | 1 | 1.1 |
| B | 32 | 35.2 |
| C | 58 | 63.7 |
| Total | 91 | 100 |



Review of Priority “A” Report

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

NYCHHC-18-03-0026: On March 27, 2018, the daughter of a Jacobi patient (the “Reporter”) called the Compliance Helpline to report that her mother’s prescription was not ready for pickup. According to the Reporter, her mother’s prescription was not sent to the pharmacy in a timely manner and her mother was in immediate danger because she did not have her medication. The OCC spoke with the Reporter who stated that her mother did receive her medication. OCC also reviewed the QuadraMed records, which showed that the prescription was filled on March 27, 2018, the day the report was made. The OCC has attempted to reach the Reporter to gather more information about the incident, but the Reporter has not returned the OCC’s phone calls. A review of the electronic medical records indicated that the

patient's medication was ordered and dispensed on March 27, 2018, and it is believed that the Reporter picked up the medication from the pharmacy.

The OCC spoke with Marisa Maloney, Assistant Director, Ambulatory Care Clinic. Ms. Maloney indicated that the prescription was not initially sent to the pharmacy as requested on March 22, 2018, because the patient needed to be reevaluated by the doctor who had written the initial prescription in case the patient's needs changed. Ms. Maloney noted that the patient had not had a proper visit with the doctor who wrote the initial prescription since April 2017 – the patient only had a brief walk-in visit in September 2017. Ms. Maloney also noted that when the Reporter went to the hospital on March 27, 2018 to pick up the prescription refill, the Reporter met with the nurse. Ms. Maloney and the nurse discussed the matter, and the decision was made to give the patient an appointment for April 2, 2018, and a prescription for enough medication to last until the April 2, 2018 appointment. Ms. Maloney stated that the patient missed the April 2, 2018 appointment, and previously missed an appointment in January 2018.

Ruth Ann Harrison, the nurse practitioner who spoke with the Reporter when she went to the clinic on March 27, 2018, and wrote the prescription for the patient's medication, noted that the patient has uncontrolled diabetes and needs to be reevaluated in case her needs have changed. Ms. Harrison also stated that the patient had missed an appointment in March 2018.

Review of Retaliation Report

15) As noted above, three (3) reports were characterized as retaliation reports. Two of those reports, however, were not actually retaliation reports, and were also determined to be unsubstantiated. The third report is summarized as follows:

NYCHHC-18-02-0006: An anonymous reporter (the "Reporter") alleged that his/her supervisor behaved in a bullying manner toward employees to the knowledge of the department's Director (Safety Management) at NYC Health + Hospitals/Gouverneur ("Gouverneur"). Briefly, the Reporter alleged that the Captain of Hospital Police did not show respect to employees, and humiliated employees by referring to them in a derogatory manner. The Reporter also alleged that the Caption of Hospital Police inappropriately allows the watch employees to



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supervise the hospital police. Finally, the Reporter stated that two petitions were signed and submitted to management, but no action has been taken. When management does speak to the Captain, she retaliates by changing the schedules, denying requested time off and overtime, or by talking negatively about employees to other employees.

The OCC Investigator discussed matter with Ms. Anna Akhrina, (Assistant Director, Human Resources at Gouverneur) on February 2, 2018. Ms. Akhrina was aware of the matter and was already addressing the issues described. As of that date, Ms. Akhrina had already recommended and scheduled "communication training" for the subject of the complaint and met with Hospital Police employee union delegates. Ms. Akhrina also said that as per the Senior Associate Director of Safety Management (the subject's direct supervisor), the subject was doing a good job but had poor interpersonal skills.

Because the allegations in the subject report appeared to involve a potential Human Resources (and/or Labor Relations) matter(s), on February 2, 2018, the OCC, pursuant to § [22][E] of Operating Procedure 50-1 (Corporate Compliance and Ethics Program), referred the matter to the Human Resources Department at Gouverneur for review and further action as deemed appropriate.

IV. Review and Updating of Compliance Policies and Procedures

Current Operating Procedure ("OP") Reviews

16) In accordance with Federal and State compliance guidelines, as well as 10 NYCRR § 405.3(d)(6), the OCC has been 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. Accordingly, the following OPs have undergone final legal review, and are expected to be ready for the President's signature this quarter.

- a. OP 50-2 (The Prohibition of Activities that Violate the Civil Monetary Penalties Law and/or Result in the Imposition of Civil Monetary Penalties);



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- b. 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
- c. OP 50-6 (Emergency Medical Treatment and Active Labor Act (“EMTALA”)), which is in its final review with Emergency Department Directors.

Upcoming OP Reviews

17) In addition to the above mentioned OPs, the following OPs are in the process of being updated for legal review:

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

V. Status Update – DSRIP Compliance Activities

Background and Legal Requirements Regarding DSRIP Compliance Training

18) 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”.¹¹ Per OMIG compliance guidance, these compliance training and education requirements extend to the DSRIP Program.

19) As reported to the Audit Committee in February 2018, 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

¹¹ 18 NYCRR §521.3[c][3]; see 18 NYCRR § 521.1; Social Services Law § 363-d [2][c].

providers' program integrity systems when dedicating resources and developing the PPS Lead's systems."¹² 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

20) OneCity Health Partners must certify annually to OneCity Health that they have met their DSRIP compliance training obligations and certain other compliance-related obligations. Accordingly, in February 2018, the OCC, on behalf of OneCity Health, distributed a Memorandum to OneCity Health Partners with a *Compliance Attestation of OneCity Health Partners* ("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.

21) The February OCC Memorandum covered 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.

Overview and Analysis of the Key Components of the OneCity Health Partner Compliance Attestation

22) The Attestation addressed, among other things, the following key topics:

¹² 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.

- The status of completion of DSRIP compliance training by a medical practice or organization;
- An acknowledgment by partners that their workforce members are familiar with and adhere to the NYC Health + Hospitals Principles of Professional Conduct; and
- Proof of OMIG compliance program-related certifications by those partners that are required by law and/or OMIG policy to submit such certifications.

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

24) The NYC Health + Hospitals' Principles of Professional Conduct ("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 were 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.



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25) 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.

26) To this end, the Attestation asked a series of questions to determine whether a Partner was 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

27) 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.¹³

28) 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 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

29) The DRA requires providers who receive or make \$5 million or more in direct Medicaid payments to annually certify through the OMIG website that they have:¹⁴

¹³ See 18 NYCRR §§ 521.2 and 521.3.

¹⁴ 42 U.S.C. § 1396a (a)(68).

- Established and disseminated to all their employees, including management, and any contractor or agent of their provider organization, written policies that provide detailed information about¹⁵:
 - 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.

30) 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.

¹⁵ See *id.*



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Total Number of Attestations Completed and Returned to OneCity Health

31) To date, of the one hundred sixty-nine (169) OneCity Health Partners who executed a Schedule B for period April 2017 to December 2017, twenty-nine (29) Partners had completed and submitted the Attestation to OneCity Health. The Schedule B is a contract amendment to the DSRIP Master Services Agreement signed by each OneCity Health Partner that outlines performance requirements to earn DSRIP funding (“funds flow”).

Audit of OneCity Health DSRIP Program by Outside Auditor

32) As reported at the February 2018 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 proposals were received in response to the RFP. The five-member committee assembled to review the RFP proposals met on February 5, 2018, to review the responses to the RFP. On February 14, 2018, the two vendors that responded to the RFP gave the committee presentations on their proposals. A final selection should be made shortly.

VI. Status Update - HHC ACO, Inc.

Background of HHC ACO, Inc.

33) 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 the Centers for Medicare and Medicaid Services (“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.



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HHC ACO Application for New York State ACO Certificate of Authority

34) As reported at the February 2018 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, and no further information has been requested by the State. 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.

VII. Aetna Desk Review

35) On January 31, 2018, the OCC received notification from Aetna of a Notice of Compliance Program Audit (the “Notice”), requesting information from NYC Health+Hospitals relating to its compliance with Medicare Parts C & D compliance program elements as required by CMS. The Notice stated that the review would include functions performed by the System (particularly the OCC) which are related to Aetna’s Medicare Advantage, Prescription Drug Plans and/or Medicare –Medicaid Plan product lines. Aetna performs such reviews to ensure that the entities their organization contracts with, such as the System, meet their compliance program obligations. These reviews are normal procedures for Managed Care Organizations (“MAOs”), and are conducted under the auspices of their “Delegated Vendor Oversight” responsibilities, pursuant to which CMS requires all MAOs to ensure that the entities with which they contract comply with certain training and education requirements, methods of reporting, code of conduct, and auditing and monitoring procedures, among other compliance activities.



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36) The Notice included two (2) information requests. The initial information request asked for items which included a sample of the System's employees who work on Aetna's Medicare products, documents regarding the System's code of conduct, general compliance training materials, fraud, waste and abuse training materials (or a declaration of deemed status), current compliance policies, and evidence of the System's oversight of its Downstream Entities, including evidence of how the System ensures their compliance with applicable Medicare requirements, and evidence of OIG and GSA SAM screenings prior to hire and for three months prior to the date of the Notice.

37) The OCC submitted its response to Aetna's initial request for information on March 8, 2018. Following this submission, a second information request asked for items which included more detailed evidence of compliance training completion, distribution of the System's code of conduct, completion of CMS General Compliance Training, and OIG and GSA SAM screenings. The second information request pertained to a sample of new hires and existing employees selected by Aetna. The OCC submitted its response to the second request for information on March 26, 2018. The OCC is currently awaiting a response from Aetna.