



AUDIT COMMITTEE
MEETING AGENDA

June 13, 2018

11:00 A.M.

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

CALL TO ORDER

Ms. Emily A. Youssouf

- Adoption of Minutes April 12, 2018

Ms. Emily A. Youssouf

ACTION ITEMS

INFORMATION ITEMS

- Grant Thornton, LLP 2018 Audit Plan
- Audits Update
- Compliance Update

Mr. Jay Weinman

Mr. Chris A. Telano

Ms. Catherine Patsos

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT



MINUTES

AUDIT COMMITTEE

MEETING DATE: April 12, 2018
TIME: 12:00 P.M.

COMMITTEE MEMBERS

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

STAFF ATTENDEES

Andrea Cohen, Acting General Counsel, Legal Affairs
William Foley, Senior Vice President, Acute Care Operations
Colicia Hercules, Chief of Staff, Chairman's Office
Jay Weinman, Corporate Comptroller
Catherine Patsos, Deputy Compliance Officer
Kevin Lynch, Chief Information Officer, EITS
Kim Mendez, Senior Vice President, System CNE
Ana Marengo, Senior Vice President, Press Secretary
Yvette Villanueva, Vice President, Human Resources
Fred Covino, Vice President, Finance
Jeremy Berman, Deputy Counsel, Legal Affairs
Robert de Luna, Senior Director, Press Secretary
Christopher A. Telano, Chief Internal Auditor/Senior Assistant Vice President
Devon Wilson, Senior Director, Office of Internal Audits
Chalice Piña, Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
John Cuda, Chief Financial Officer, MetroPlus
Jose Santiago, Controller, MetroPlus
Glenford Hall, Assistant Director, H + H/Kings

OTHER ATTENDEES

GRANT THORNTON: Tami Radinsky, Partner; Louis Feuerstein, Managing Director
PAGNY: Anthony Mirdita, Chief Financial Officer
OSC: Justine DeGeorge

**APRIL 12, 2018
AUDIT COMMITTEE MEETING
MINUTES**

A meeting of the Audit Committee was held on Thursday, April 12, 2018. The meeting was called to order at 12:21 P.M. by Ms. Emily Youssouf, Audit Committee Chair. The minutes of the Audit Committee meeting held on February 7, 2018 were presented to the Committee for approval. A motion was made and duly seconded, the Committee unanimously adopted the minutes. Ms. Youssouf stated that later in the meeting there will be a motion to hold an Executive Session of the Audit Committee.

Ms. Youssouf directed the first action item to Mr. Jay Weinman.

Mr. Weinman introduced the following 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.

Ms. Youssouf open the resolution for discussion, and requested Mr. Weinman to proceed with his presentation

Ms. Andrea Cohen, Acting General Counsel, stated that she will be presented first regarding the procedural elements and Mr. Weinman is going to present about the qualifications of Grant Thornton. In terms of our process, the Contract Review Committee (CRC) approved the issuance for request for proposals (RFP) for audit services in January. The RFP was issued shortly thereafter. In 2018 we had a pre-bidders conference in February 2018 and responses to the RFP were received from six audit firms at the end of February.

First round scoring occurred on March 5, 2018 and the two highest rated firms, Grant Thornton and KPMG, were invited for interviews with the selection committee on March 12, 2018.

With respect to the proposals, the proposal fees had a fairly wide range with respect to the cost, from \$3.3 million to \$11.3 million. As I mentioned before, KPMG and Grant Thornton were both determined to be the leading proposers and determined to be competent to perform the scope of work that was in the RFP. Grant Thornton's fee proposal is marginally lower than KPMG's and is on the lower end of that range. As you heard in the resolution the total is of \$4,452,225 that is being sought at this point.

Using the authority that was available to him once the two leading proposers had been selected, the president, in the best interest of the system, determined that he would recommend to the Audit Committee that we enter into a contract with Grant Thornton on the basis that a new, highly qualified auditor, which the selection committee had determined it was, would be able to provide a needed fresh perspective on the system's controls and audit. I should note that there has been a long tenure using KPMG prior to this point in time.

Mr. Weinman stated that Grant Thornton is ranked the sixth largest accounting firm in the Metro area. They are a Chicago based firm. They are also sixth rated nationwide. They are the City's auditors since 2016. They switched from Deloitte who they had for about 14 years. There are over 600 professionals nationally dedicated specifically for health care and they have 1,280 health care clients, including Westchester County Health Care Corporation and the Nassau University Medical Center.

The audit team will dedicate two partners for this engagement, Tami Radinsky, partner, she will be the lead partner and Louis Feuerstein. He is the managing director and also the compliance services partner. Both have extensive experience within the health care industry. They come from Big Four accounting firms. Lou was a partner before. Both of them are here today if there are any questions.

Ms. Youssouf asked them to approach the table and introduce yourself. Tami Radinsky, Partner; Lou Feuerstein, Manager Director.

Ms. Radinsky reported - I joined Grant Thornton about a year ago. My two clients that I have worked on at Grant Thornton are Westchester Medical Center and Nassau University Medical Center as mentioned above. Prior to Grant Thornton I spent 17 years at Price Waterhouse Coopers, all in the health care space, and I have probably touched every hospital system in New York City throughout the 17 years of my career. I am really excited to be here and I look forward to working with you.

Mr. Feuerstein thank you for inviting us to the table. I am looking forward to working with NYC Health + Hospitals. I have been with Grant now just about four years. Prior to that I spent all of my career, essentially all of my career, with Ernst and Young. I was a partner there for years. If you are familiar with the Big Four routine, they all have mandatory retirement ages. Not being rich enough or ready enough to retire, I decided to continue on my career. Fortunately I joined Grant Thornton. The client Westchester Medical Center is actually my client as well. It is a large system. They also own and operate the Bon Secours Health System, which is three hospitals. The Kingston Hospitals, which is now Health Alliance. Grant Thornton does the audit work for all those. For the last three years we have been the auditors of Nassau University Medical Center. We took that from the Big Four, they just went out for bid in the last three or four months and we were reappointed for another three years.

Ms. Youssouf asked if Grant Thornton has any clients that are large health care systems. I mean as large or close to as large as H + H is?

Mr. Feuerstein answered that the first one I threw out is Westchester Medical Center. It is about eight or nine hospitals and really close to your size. Nassau Medical Center is smaller but they have a very large skilled nursing facility. We pick up experience there. As a firm, we spend time with and provide audit and advisory services to some of the largest health systems in the country. For example, we are doing work now for CMS itself. That is in the \$20 to \$30 million a year range. Grant Thornton is a big firm with a lot of bench strength and horsepower, especially in health care.

Mr. Campbell asked that this will be a new engagement, this enterprise is sprawling messy, complex and the like. How would you see you getting up to speed understanding it and hitting the ground running?

Ms. Radinsky responded that we transition clients all the time. As Mr. Feuerstein mentioned, I would say we have a laundry list of clients we have transitioned over the past five years or so that have been with their long-standing predecessor auditors for 15, 20 years. Many of them, or most of them from the Big Four firms. We are familiar with this process. We have a very robust work plan in terms of the transition process.

The first would be to meet with Mr. Weinman and his team to understand current processes in place. We do not want to recreate anything so to speak from a business perspective, but really understanding what you are currently using. The requests, the forms that you are currently filling out and the documents that you are producing. Then what we will also do as part of the ongoing or onboarding process is meet with your predecessor auditors, meet with a partner at KPMG, the team review, the work papers, the files, so that there is no duplication of efforts. Then we start the planning process very early. We have a health care specific file and database that we use at all of our clients to execute our audits. So it is a seamless transition.

Mrs. Bolus asked it sounds like most of it is in hospital patients and you are dealing with that kind of stuff. We are going towards ambulatory now. Would you be able to do that also?

Mr. Feuerstein answered absolutely because you are exactly right. It is a trend now. Population health management and getting away from inpatient to more community-based systems. For example, NUMC has a relatively robust FQHC. So we are familiar with that. I have audited the FQHC. We are familiar with outpatient, long-term care, post-acute care, services outside the wall of the hospital.

Mrs. Bolus stated that we just saw a diagram of all of our small little areas that we have and we are going to build more. It is going to be more than just 11 hospitals. More like 70 different types that are identified at this point and may have more later. That is a huge, spread out area.

Mr. Feuerstein responded that we have got the experience and the capacity. One good advantage you may or may not be aware of, essentially all of the health care providers in New York, even New Jersey, they are all December 31st year end. We have built a rather large and experienced staff to service those. But you are June 30th, it is kind of a nice transition. We will be having our folks rotate off those year-end jobs and have the experience, the bench strength and capacity to visit those types of locations and make sure they are properly accounted for.

Mr. Weinman illustrated the rest of the partners on the job, including the tax partner as follows: Frank Kurre, Partner, Northeast Regional Leader; Dana Wilson, Partner, Insurance Industry Audit Practice Leader and Daniel Romano, National Managing Partner, Not-for-Profit Tax Leader.

We utilize tax services pretty frequently. Especially with the new tax laws. We have the partner related to the MetroPlus and HHC insurance. So they are all assigned just the names here, they are not here, just wanted to show you the bench strength that they are offering us.

Ms. Youssouf added that just a couple of other things I wanted to mention. One is that we request that you do not use our internal audit staff for your audit. That has been the practice in the past. But at this stage, the number of staff people are no longer available. So I just want to be sure that is going to be okay.

Mr. Feuerstein said that I know that it is part of the RFP process. Mr. Weinman had mentioned that right from the start.

Ms. Youssouf asked if you will do the calling of the audit chair and some other people with any questions once a year when we talk to them. You are going to do all the stuff we would normally expect?

Ms. Radinsky answered that I can speak that coming from a Big Four recently, it is the same process in terms of meeting with the audit chair at your disposal. Whenever you would like, we can have formal meetings throughout the year. We are available, we have the resources of the Big Four firms but we have the flexibility of some of the smaller firms. A lot of partners on-site, I do not want to use the words hand holding, but interaction communication.

Mr. Feuerstein added that we understand that we are actually engaged by the Audit Committee, the board, not management. We open up frequent lines of communications. It will be a two way communication if you have questions and concerns reaching out to us as well.

Ms. Youssouf thanked them and asked if there were any questions?

Ms. Landaverde asked if throughout the period of the contract there are reports coming back to you or you guys. Is that still going to continue like monthly, quarterly?

Mr. Weinman answered that for the Audit Committee, we bring to the Audit Committee the audit plan usually in this case will be June. We do not have a meeting in May. Grant Thornton will be available to answer any questions. They will present exactly what they are going to audit. We have the year-end audit and the results will be presented sometime in October when we finish all the field work and we get all the pension and OPEG data from the state. Then they will come back to deliver the management letter and that's usually sometime in November, December. The later the audit continues unfortunately they will postpone the management letter. But those three are major meetings that Grant Thornton will attend to address the committee.

Ms. Youssouf asked can I have a motion to accept this resolution. It was unanimously approved. Thank you. Congratulations, it still has to be approved by the full board but I am sure we will be seeing a lot of you.

Ms. Youssouf then directed the meeting to Ms. Catherine Patsos.

Ms. Patsos introduced the following 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.

Ms. Youssouf asked if she had the answer to the question regarding compensation?

Ms. Patsos answered that we are definitely going to look to that in the next six months with regard to the compensation.

Ms. Youssouf asked if it is the same position or different? To which Ms. Patsos responded that the position is the same. I am saying the restructuring of the department is requiring this position to be replaced. So we will be looking for compensation increase within the next six months.

Ms. Youssouf asked if there were any questions.

Ms. Landaverde asked if this is not a new position. It's a replacement?

Ms. Youssouf answered that it is in addition to someone's current responsibility. We just want to be sure that they are getting compensated appropriately. It is a big addition to their portfolio.

Ms. Youssouf asked for a motion to approve this resolution? It was unanimously approved.

Ms. Youssouf then directed the meeting to Mr. Chris Telano for Audit updates.

Mr. Telano reported that we will start with an external audit that was completed by the State Comptroller's Office that was originally titled Nurses Qualifications when they began the audit in May 2017. We received the final draft report on March 27, 2018 and the new title of the report is Oversight of Nurse Hiring and Retention. The response is due to the Comptroller's Office on April 27th and it will be prepared by Ms. Kim Mendez, Senior Vice President and Chief Nursing Officer and/or Yvette Villanueva, Human Resources Vice President.

The audit entailed reviewing the personnel files of direct hire and temporary nurses to ensure that certain documents were in the files.

Below is a summary of all the exceptions.

SUMMARY OF FINDINGS

	Bellevue	Home Health Agency	Kings County	Lincoln	Gouverneur	Totals
Direct Hire Nurses						
Sample Number	40	40	40	40	40	200
Not licensed at time of hire	0	0	3	0	1	4
No I-9 verification on file	1	1	9	5	14	30
No fingerprint results on file	10	3	10	6	12	41*
No MQR check	0	4	1	1	0	6
No OIG search	1	1	6	1	2	11
No OMIG search	1	10	4	0	1	16
No EPLS/SAM search	1	2	4	0	0	7
No current annual evaluation	0	24	1	0	0	25
Temporary Nurses						
Sample Number	20	19	20	20	19	98
Not licensed at time of hire	0	0	0	0	0	0
No I-9 verification on file	20	19	20	20	19	98
No fingerprint on file	20	19	20	20	19	98
No MQR check	0	0	0	0	0	0
No OIG search	0	0	0	2	7	9
No OMIG search	0	0	0	2	10	12
No EPLS/SAM search	0	0	0	2	9	11

*Fingerprinting was not required until January 29, 2002. The majority (38) of the direct hire nurses were hired prior to this date. Only 3 (one each at Bellevue, Kings County, and Gouverneur) were hired after 1/29/02, when fingerprinting became a requirement for all direct hire nurses.

Note – Form I-9, or the Employment Eligibility Verification form, is required to be completed by all employees (citizens and non-citizens) hired after November 6, 1986. The purpose of the form is to document that each new employee is authorized to work in the United States.

As you can see it is broken into two sections, the direct hire nurses in which they tested 200 files and the temporary nurses in which they tested 98 files. As you can see the exceptions are all the same. Not licensed at the time of hire. No I-9 verification on file. The I-9 form, for clarification, is the employment eligibility verification form. Then the next exception is no fingerprint results on file.

And there is a footnote on the bottom of this table which states that fingerprinting was not required until January 29, 2002. And of the 41 exceptions for the direct hire nurses 38 were hired previous to this date. Hence, only three were hired after January 2002 at three different sites.

Then the next four rows, MQR, OIG, OMIG and EPLS are all background check documents. Then no current annual evaluation is the last item on the direct hire nurses.

Ms. Youssouf asked would you like to discuss what your plan of action is or response to this audit.

Mr. Campbell stated that even before that, maybe talk about what currently the responsibility is of the temporary agency.

Ms. Villanueva reported that we can start with direct hires. It is the expectation that based on the effective date that every employee have an I-9. So, during the audit they looked for I-9s at the time of hire. If the I-9 was there after hire, whether it was a year, ten years after, they consider it a citation. However, we do have variability within all of the Health + Hospitals facilities for various reasons. I-9s are kept separately in different locations. In some facilities things are stored in city storage and during the fire some of the information was destroyed. Some things were affected by flood, etcetera.

However, we have the obligation to maintain current documents. And so, every facility is in the process and has already done some auditing to determine what the gaps are. If there are any gaps, like the I-9s, we are required to have employees fill it out. It does not mean that we are not comfortable in realizing and understanding that our employees are eligible for employment, because they are, it just means that we have to keep that document on file. In terms of the evaluations, particularly for home health which was our biggest vulnerability, they do understand that it is expected that every single employee is required to have an evaluation.

Ms. Youssouf asked when you say "they" are expected who is they? To which Ms. Villanueva answered the managers.

Ms. Youssouf asked of who?

Ms. Villanueva responded of Home Health and the CEO who is relatively new, Vickie Norvell. She has been incredible in holding the staff accountable for ensuring that they are completing performance evaluations. We are monitoring that as well. We are going back to do actual physical audit so that we can validate that these things are in place.

Dr. Katz asked is our system for evaluations is computerized? To which Ms. Villanueva answered yes.

Dr. Katz then stated that that then it should be pretty easy to see compliance.

Ms. Villanueva added that electronically we can. However, some may require a wet signature, which for our unionized staff it still does.

Dr. Katz stated that the world has moved beyond wet signatures.

Ms. Villanueva added that we have already incorporated that for our managers. They are using PeopleSoft and it is an electronic signature. We know that the technology is there.

Dr. Katz stated, I know this is diversion, but you really think the contract says that we will evaluate people and that there will be a wet signature on the bottom of the evaluation?

Ms. Villanueva said that it is also our technology. We have not yet gone there with our technology. We want to make sure we inform our union, this just is not going to be a performance evaluation, and we want e-signatures for a whole lot of other things. We are going to have one conversation but we need the technology to follow that. That will be a plan going forward.

Ms. Youssouf asked do we know if this is common practice from the union everywhere?

Ms. Villanueva responded that every person is required to have an evaluation regardless if it is e-signature or wet.

Ms. Youssouf stated I meant wet signature.

Ms. Villanueva answered that I think it varies, it is a combination. But we can do e-signature. I do not think it is something that we cannot do. By law or regulation I think we can. It is just a matter of making sure that the technology is there to do it and then we clearly communicate with our partners the plan going forward and we intend to do that.

Ms. Youssouf asked you are discussing this obviously with IT? To which Ms. Villanueva answered yes. They have already implemented the managerial component of it. We know it works, it's been tested, and it's been piloted. It works beautifully.

Ms. Youssouf stated great.

Ms. Mendez then addressed the temporary staff. We utilize Vizient, which is a consortium of nursing vendors and other health care providers that come under that contract as well. There is a wide variety of nursing vendors that we utilize under Vizient. The reason for saying that is as we get individuals we put our order out and we say we would like to have a nurse for ICU. Then it goes out to Vizient and comes back to us and there is a checklist of credentials that we require that the vendor check and do an attestation for. I would just like to go on record saying that as the new Chief Nursing Officer when this first started, I actually see this as a gift from our Office of the State Comptroller. Because it did provide us with an opportunity to look at an area that we may have not have looked at right away. We actually found some vulnerable and opportunities to improve. With that, we did find we have variation at each facility on how we keep files, either electronically or on hard copy on our vendor staff, and our agency staff. We have put a corrective action into place. We have developed a new agency checklist that the vendor will check off. There is an e-filing system called Optimizer with Vizient that will be able to upload all the documents and pull them down when needed for audit.

Ms. Youssouf asked if it is uniform now.

Ms. Mendez answered that the Optimizer is uniform. We actually did have At Home, that did not have this available to them and that has been corrected. The other area that came out was the fingerprinting. It is not a regulation and it has not been our practice here in New York City Health + Hospitals to fingerprint all of the agency staff. That is a new ask or a recommendation by the Office of the State Comptroller. Even though you see it as a deficit, it was not part of our practice. Albeit there is a component in our contract that states if it is a skilled nursing facility that we ask, for that vulnerable population, that there be a check.

We have looked to see what our opportunities are around fingerprinting, and we have worked into our contract with Vizient that we will begin New York City fingerprinting on all of our nursing staff as they are hired. RNs, LPNs etcetera. That has actually started, I forgot the exact date, I want to say March 1st for our staff but I will get the correct date. I want to make sure I go on record with the right date on that.

One of the things that was also recommended is that we, in addition to having the review by the vendor that all of the components of the background check are in place, is that we have a New York City Health + Hospitals official review also. And that will be added to our checklist, so that we ensure that we have a New York City Health + Hospital official reviewing to make sure all the background information is in place that the vendor has said has been validated prior to the hire of the agency nursing staff.

Mrs. Bolus asked are you going to grandfather the others in. To which Ms. Mendez responded that what happens is, they are on a limited contract. For them to continue they have to be re-procured in our system. Once they come back through they will be fingerprinted because that is our new policy. There is a mechanism in place that will secure that. Actually it started February 1st.

Ms. Landaverde asked where the fingerprinting takes place. Is that in-house?

Ms. Mendez answered that it is done outside of New York City Health + Hospitals. It is done NYPD. And it is at the cost of the vendor prior to the individual coming here. It is not a cost that is assumed by New York City Health + Hospitals. That will be something new for us as we move forward. We have already started that component. Then from an audit perspective we are partnering with HR, who will be supporting the audit process.

Mrs. Bolus asked how long does this take from the time it takes a person signs up with us to actually being able to utilize them?

Ms. Mendez answered that we actually do not sign anybody up until they have met the criteria. So we put a request out for ten people let's say and so they know that we are requesting this, so they proactively have all these documents kind of going if you will. When we ask for somebody they have to check to make sure they are valid. Then they will send us the resume with the checklist, so we can review that. It depends on the type of individual. Sometimes it takes longer for a specialty, ICU, neonatal, that type of role. Not so much for med surg and other areas. It depends on the role.

Ms. Youssouf asked do we fingerprint, as a matter of course, just medical staff or do we do everybody?

Ms. Villanueva stated for our employees we do everyone. For those that are under the category for the DOI, Department of Investigation, they do them directly. For example, managers or any over a certain amount of income and individuals that deal with computer programs. That fingerprinting is done by them.

Ms. Youssouf asked if for the other contractors, because we have a lot, do we get some kind of attestation that they have gone through this, other than the temporary nurses, or do we not do that?

Ms. Villanueva answered that I am not aware that we do that. It is one of the gaps that we are looking at when we do our audit. We are going to be looking at the other types of staff that come from other agencies that they call themselves either consultants or staff. We are going to be looking to see what they do in terms of their own checks. And again, if that is not happening that is an easy fix. Something that we can require them to do.

Ms. Youssouf added that I would urge you to try to take a look at that because it is an easy fix. Sooner rather than later. Especially considering, aside from just those people on a clinical aspect, but when you look at all the people we have

on contracts for IT and very sensitive information, I think it is probably a good idea to take a look at that. I do not want to give you more work. I am not trying to.

Ms. Villanueva stated that that is part of the plan.

Ms. Youssef said that then you could come back to us and let us know.

Mr. Telano reported that another audit is being done by the State Comptroller's Office. This one is of equipment. The objective of the review is basically doing a physical verification and depreciation and reviewing our disposal policies and procedures. It is an ongoing audit. They have been to a few sites and they will continue to go to other sites.

Mr. Telano then stated that that concludes my presentation.

Ms. Youssef then turn the meeting over the Ms. Catherine Patsos, Acting Chief Compliance Officer for a compliance update.

Ms. Patsos reported that the first item in the report is the monitoring of excluded providers. The Office of Corporate Compliance monthly screens providers to ensure that they are not excluded from state or federal databases that would exclude them from being able to being paid for furnishing services at Health + Hospitals. Through this monthly screening, we did identify one nurse whose licenses had been suspended December 5, 2017. We were alerted to this in the January monthly exclusion report. Immediately thereafter the Office of Corporate Compliance and Woodhull's human resources met with this particular individual and placed him on inactive status without pay. Because the nurse had provided services in the behavioral health department in Woodhull we are not allowed to receive federal, or state reimbursement for someone whose license is suspended. On March 30th we submitted a letter to the New York State Office of Medicaid Inspector General (OMIG), to identify the potential overpayment for Medicaid.

On April 4th we also sent a letter to National Government Services, which is the federal Medicare administrative contractor for the Medicare program, requesting guidance on whether there had been a Medicare overpayment.

With regard to the Death Master File and National Plan and Provider Enumeration Screening Process there were no providers identified on either of those data banks.

Ms. Patsos reported on the privacy and incident-related reports for the first quarter of 2018. There were 33 privacy complaints that were recorded in our RADAR system, which is our incident tracking system. Of those, 18 were found to be violations of the systems privacy and security operating procedures. Eleven were determined to be unsubstantiated. Two were under investigation and two were found not to be in violation of the policies and procedures. Of the 18 incidents that were found to be violations, ten were determined to actually have been in breach of protected health information, for which notifications were sent to the affected individuals.

The primary cause of the unauthorized disclosure which resulted in the breaches of health care information was providing patient information of one patient to another patient that was not supposed to have received that information. Whether it was verbally, through handing over a discharge form, things of that nature, those are being addressed with

corrective action to retraining and addressing those issues through the hospital and some of the hospitals' senior leadership to make sure those things do not reoccur.

The one particular note is the Harlem Hospital January 2018 incident. This involved a missing unencrypted laptop from the Audiology Department. What had occurred in this instance was the audiologist had stepped away from the laptop computer, from the room, for a few minutes. Upon her return the laptop was missing. There was an investigation to try to find the laptop, which was not found, and it was determined to have been stolen. This particular incident involved 595 affected individuals. Because it involves over 500 individuals, notification, as required by federal regulations, was sent to the secretary of the US Health and Human Services Department. As well as to two media outlets, the New York Times and Wall Street Journal. That is also required under the federal HIPAA regulations.

Dr. Katz commented that, he was just wondering, besides the encryption, which I know we are going to make sure all of our laptops going forward are encrypted, does the technology exist to put GPS devices on laptops the way they do on phones?

Ms. Youssouf asked Mr. Lynch to approach the table.

Ms. Patsos reported that I did some research after the briefing to determine what the current process is, and we do have a process in place for the laptops and computers and devices of that nature that are vetted through the Enterprise Information Technology System (EITS). They get tagged and they go through the whole process of getting encrypted. With regard to a PC that is not a part of the biomedical device, medical devices are often accompanied by a laptop, those are not, because of FDA certification, those two components of bio medicine devices and the accompanying laptop, are not segregated. So there is no policy for the centralized purchasing of those particular devices and their accompanying laptops.

I believe there should be. However, I think there is also an allocation of resources that we have to make a decision on because that would be, I believe as I understand it, very burdensome for EITS currently to be able to review and tag and asset control every single biomedical device and accompanying laptop that comes through the system.

Mr. Lynch stated I would agree. This is a challenging part of technology where biomedical devices that come with laptops we buy the product. And in my past experience that has been a challenge. But I do think we need to set a policy that anything that touches our network has to live under the rules of our network, which include encryption and patching, to avoid hacking from the outside and security and theft of those devices. Although, yes, it will be challenging, I think that we really need to advance the policy and then the enforcement of the policy. That goes to the procurement process and the governance model that we talked about earlier in the IT Committee. We are going to have to do a review of what is out there right now and come up with an addressable policy to that.

Ms. Youssouf stated I would just ask that you come back to the committee and let us know when you are able to determine what the policy is and how you are going to enforce it. Because the concept that we have all these God knows how many of these are out there. We have a big system.

Dr. Katz commented that even when you say touch our system, some of them may not touch our system. Some might be like a device with a laptop and it is not actually even on your network. The good thing about those is that they cannot

use those to hack into our system. That is the positive of those. But then we also need a way of making sure those are secure, right?

Mr. Lynch said that those are the most challenging. The one that has to actually be plugged into our network for some reason we can sniff those out. The ones that are stand-alone will be much more difficult.

Ms. Patsos continued and said that as to mitigating steps with regard to this particular incident, Harlem did immediately notify local law enforcement. They are reviewing their physical security environment and looking into placing more cameras so we will be able to detect something like this occurring in the future. As I mentioned also, we are going to be working with EITS, as we just discussed, on new procedures to ensure that these types of incidents are certainly minimized if not recurring at all. We did engage a third-party vendor, Kroll Information Assurance, to provide theft identification services to the 595 individuals who were affected by this particular breach.

Moving on to the compliance reports for the first quarter. There were a total of 91 compliance reports that were received through our hotline. One of them was a priority A, which requires immediate attention as a result of a potential threat to personal property or the environment. Thirty two were classified as priority B and 58 as priority C.

Summary of the priority A report, which involved a reporter, who was the daughter of a patient at Jacobi, who complained that her mother's prescription was not ready for pick up on the particular date, March 27th, of her report. Upon investigation it was determined that the medication was in fact ordered and dispensed on that date.

Reviewing and updating compliance policies and procedures. We have been working on several operating policies and procedures to update them and to bring them to completion. What I am looking for this next quarter is the Civil Monetary Penalties Law, the Fraud, Waste and Abuse and False Claims Act penalty and the Emergency Medical Treatment and Active Labor Act, or EMTALA, which is going through its final review with stakeholders right now. And hopefully will be coming before Dr. Katz's for signature very soon.

Additional upcoming reviews of operating procedures would be reporting of overpayments and excluded providers.

The update status on the DSRIP compliance activities. As we reported in February of this year, the Office of Corporate Compliance on behalf of OneCity Health sent out attestations to all the partners, which required them to confirm that they had completed their compliance training requirements and the method by which the training had been completed. It required them to attest as to whether or not they met the requirements of the systems principles of professional conduct or had initiated their own code of conduct similar to principles of professional conduct. The attestation also required the partners to confirm that they had completed their Social Services Law, Section 363-d certification. Certification requires that they have a compliance program in effect. It requires them to have attested that they completed the Deficit Reduction Act of 2005 certification, which requires that they provide education training on False Claims Act, federal and state False Claims Act, and Fraud, Waste and Abuse Laws and Regulations.

Of the 169 attestations that were sent out we have received 29. The date for the attestations to be returned is June 30th. Based on my conversations with OneCity Health, they will be reaching out in May to those partners who have not yet returned their attestations.

Finally, with regard to this program as mentioned in the February report, we sent out an RFP to outside auditing firms to audit the OneCity Health Program. We received two responses to the request for proposal. On February 14th those two vendors gave presentations to the selection committee, and we are expecting the final selection will be made shortly.

On the status update for the HHC ACO, Inc. The application that the HHC ACO, Inc. had submitted to the State to be an all payer ACO is still pending and no further information has been requested from the State. There is no particular update from the last report.

Finally, we are undergoing an Aetna desk review, which is not an on-site review. It is a paper review. This is part of a managed care organization operating under Centers for Medicare Medicaid Services normal process that they are required to do under their delegated vendor oversight responsibilities. CMS requires managed care organizations to provide oversight of any of the entities that they contract with to make sure that they are complying with the training and education requirements, that they have codes of conduct in place, that their methods of reporting are in compliance, and their auditing and monitoring procedures are in compliance.

This particular desk review involved two requests for information. The first one being a sample of our employees, a description of our compliance with the CMS Medicare Parts C and D training, how we conduct that training, and the distribution of our policies. From that list of that sample of employees, Aetna selected two lists existing of new hires and existing employees and requested further information regarding how the code of conduct is disseminated and trained and how we provide oversight of our downstream entities.

We submitted the first response for information on March 8th and the second response on March 26th and we are waiting to hear back from them on that.

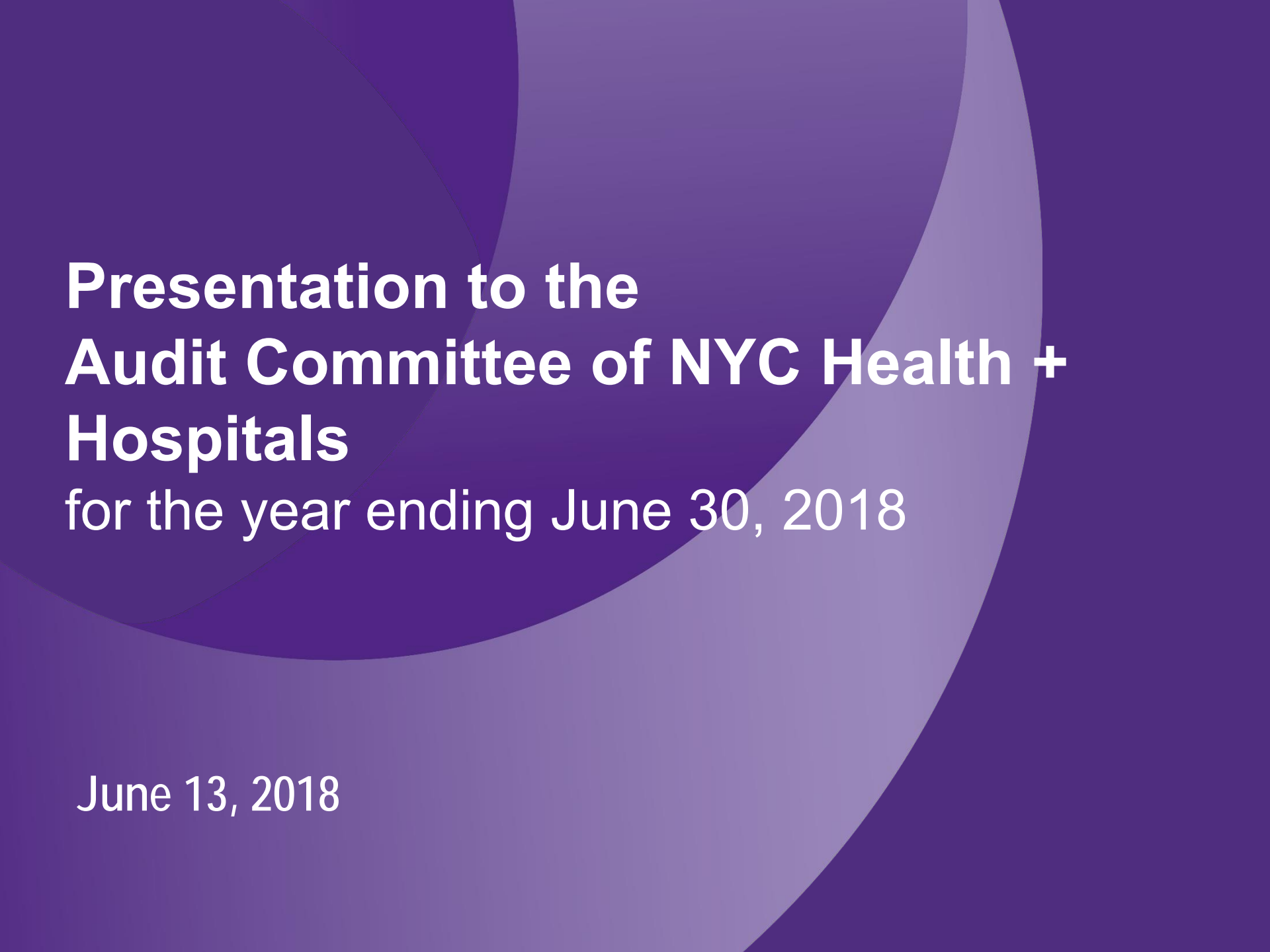
Ms. Patsos then stated that concludes my report.

Ms. Youssouf said thank you all very much. We are now going to go into executive session and I would like Chris Telano and Catherine Patsos to stay.

(Committee recessed to Executive Session.)

Ms. Youssouf stated that we are now back in full session. In the executive session we discussed matters relating to possible litigation.

There being no further business, the meeting was adjourned at 1:40 P.M.

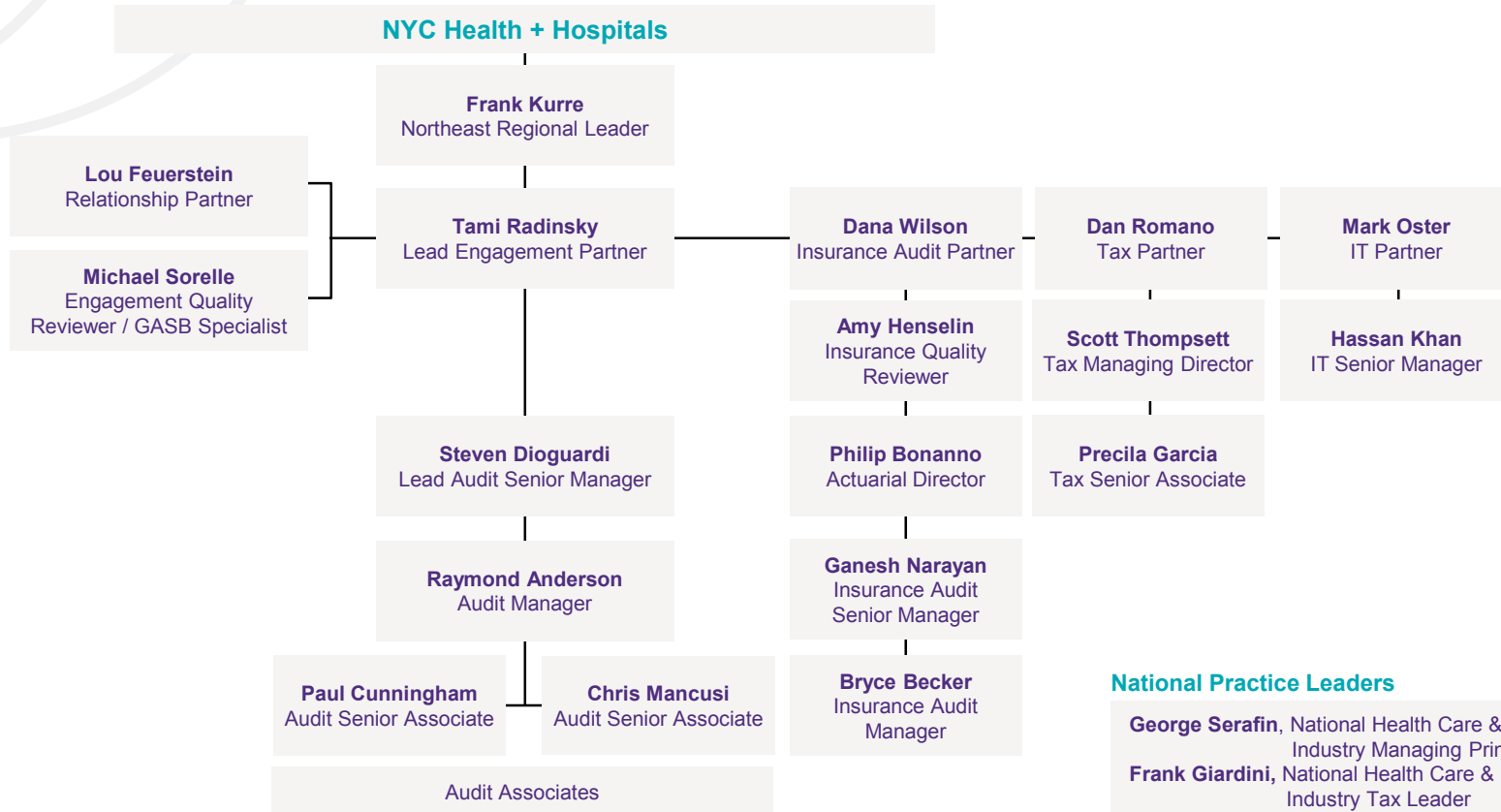
The background is a solid dark purple color. Overlaid on this are several large, overlapping circles in lighter shades of purple, creating a layered, geometric effect. The circles are positioned such that they frame the central text.

Presentation to the Audit Committee of NYC Health + Hospitals

for the year ending June 30, 2018

June 13, 2018

Team structure



National Practice Leaders

George Serafin, National Health Care & Life Sciences Industry Managing Principal
Frank Giardini, National Health Care & Life Sciences Industry Tax Leader
Erik Shannon, National Health Care Sector Leader
David Howard, Northeast Health Care Advisory Leader

Data Analytics Specialists

Brian Wolohan, Audit Data Analytics Director
Rich Lanza, Audit Data Analytics Director

Responsibilities



Our Responsibilities

We are responsible for:

- Performing the following audits of financial statements as prepared by management, with your oversight, conducted under US Generally Accepted Auditing Standards (GAAS) and, where applicable, under *Government Auditing Standards*:
 - NYC Health + Hospitals for the fiscal year ending June 30, 2018
 - HHC Accountable Care Organization Inc. annual financial statements for the fiscal year ending June 30, 2018
 - Metro Plus Health Plan's annual statutory financial statements for the fiscal year ending December 31, 2018
 - HHC Insurance Company's annual statutory financial statements for the fiscal year ending December 31, 2018
- Forming and expressing an opinion about whether the financial statements are presented fairly, in all material respects in accordance with US GAAP
- Reading other information and considering whether it is materially inconsistent with the financial statements
- Performing the following audits, as applicable, of cost reports for the year ending June 30, 2018 and issuance of certifications and attestation reports:
 - Annual Report of Ambulatory Health Care Facility (AHCF-1)
 - Annual Report of residential Health Care Facility (RHCF-4)
- Communicating fraud risks to you identified during our audit
- Communicating specific matters to you on a timely basis

An audit provides reasonable, not absolute, assurance that the combined financial statements do not contain material misstatements due to fraud or error. It does not relieve you or management of your responsibilities. Our respective responsibilities are described further in our engagement letter.

Those Charged with Governance and Management Responsibilities

Those Charged with Governance

Those charged with governance are responsible for:

- Overseeing the financial reporting process
- Setting a positive tone at the top and challenging NYC Health + Hospital's activities in the financial arena
- Discussing significant accounting and internal control matters with management
- Informing us about fraud or suspected fraud, including its views about fraud risks
- Informing us about other matters that are relevant to our audit, such as:
 - Objectives and strategies and related business risks that may result in material misstatement
 - Matters warranting particular audit attention
 - Significant communications with regulators
 - Matters related to the effectiveness of internal control and your oversight responsibilities
 - Your views regarding our current communications

Management

Management is responsible for:

- Preparing and fairly presenting the consolidated financial statements including supplementary information in accordance with US GAAP
- Designing, implementing, evaluating, and maintaining effective internal control over financial reporting
- Communicating significant accounting and internal control matters to those charged with governance
- Providing us with unrestricted access to all persons and all information relevant to our audit
- Informing us about fraud, illegal acts, significant deficiencies, and material weaknesses
- Adjusting the financial statements, including disclosures, to correct material misstatements
- Informing us of subsequent events
- Providing us with certain written representations

Views of those charged with governance

Discussion points

- Risks of fraud
- Awareness of fraud
- Awareness of related party transactions; understanding of purpose of related party transactions
- Awareness of whistleblower tips or complaints
- Oversight of management's risk assessment process
- Views about NYC Health + Hospitals' objectives and strategies and related risks of material misstatement
- Awareness of any internal control matters and views about management's response
- Oversight of financial reporting process
- Actions taken in response to developments in law, accounting standards and corporate governance matters
- Actions in response to our previous communications, if any

Audit Timing & Scope



Audit Timeline

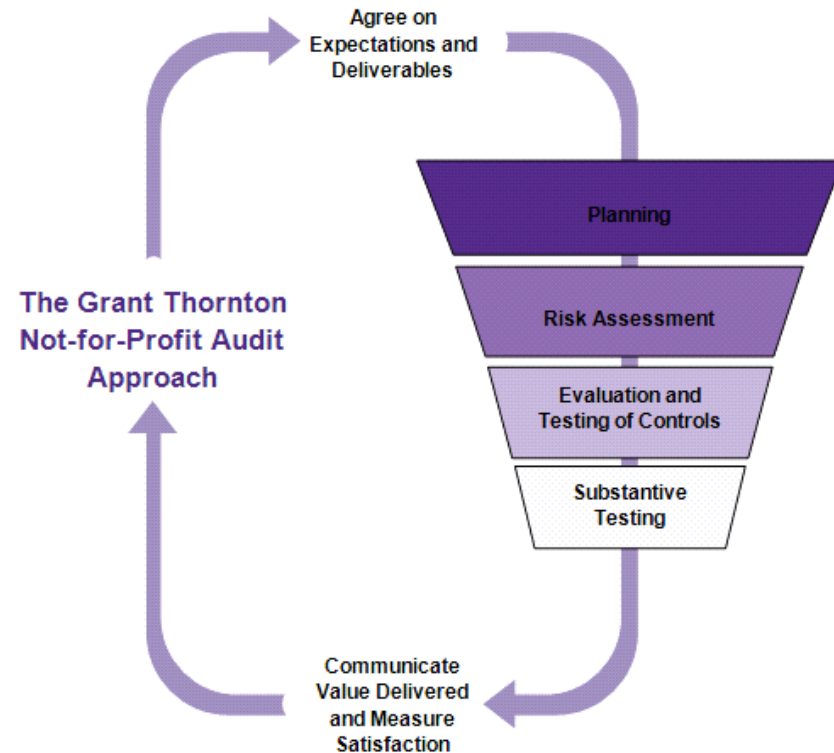
May - June 2018	Client acceptance	<ul style="list-style-type: none"> • Client acceptance • Issue engagement letter • Conduct internal client service planning meeting, including coordination with audit support teams such as IT and tax
May – June 2018	Planning	<ul style="list-style-type: none"> • Meet with management to confirm expectations and discuss business risks • Discuss scope of work and timetable • Identify current-year audit issues and discuss recently issued accounting pronouncements of relevance • Initial Audit Committee communications
June 2018	Preliminary risk assessment procedures	<ul style="list-style-type: none"> • Develop audit plan that addresses risk areas • Update understanding of internal control environment • Coordinate planning with management and develop work calendar
June – July 2018	Interim fieldwork	<ul style="list-style-type: none"> • Perform walk-throughs of business processes and controls • Perform control testing over healthcare revenue cycle • Perform selective substantive testing on interim balances
July – September 2018	Final fieldwork	<ul style="list-style-type: none"> • Perform final phase of audit and year-end fieldwork procedures • Meet with management to discuss results, draft financial statements and other required communications • Review final “draft” reports and other deliverables
October 2018	Deliverables	<ul style="list-style-type: none"> • Present draft reports and audit results to the Audit Committee and management • Issue final audit reports and other deliverables
December 2018	Deliverables	<ul style="list-style-type: none"> • Present final management letter to the Audit Committee

Audit Timeline (continued)

December 2018 - January 2019	MetroPlus Health Plan	<ul style="list-style-type: none"> • Perform walk-throughs of business processes and controls • Perform control testing over significant business processes • Perform selective substantive testing on interim balances
February 2019 – March 2019	MetroPlus Health Plan	<ul style="list-style-type: none"> • Perform final phase audit and year-end fieldwork procedures • Meet with management to discuss results, draft financial statements and other required communications • Issue the final audit report and other deliverables
April 2019 – August 2019	Cost Report Certification and HHC Insurance Company	<ul style="list-style-type: none"> • Perform applicable audit procedures and issue auditor's reports on cost reports for the skilled nursing facilities (RHCF-4) and diagnostic and treatment centers (AHCF) • Perform HHC Insurance Company audit and issuance of audit report
Timing to be determined	HHC ACO, Inc.	<ul style="list-style-type: none"> • Perform HHC ACO, Inc. audit and issuance of audit report (2018)

Our Audit Approach

The audit – a five-step approach	
1. Planning	In this phase we will update an understanding of and document your operations, control environment, accounts and information technology systems.
2. Risk Assessment	We use our understanding of your internal control system and operations to identify the inherent audit risks and strengths of your operations and information systems. By performing our risk assessment, we customize our audit approach to focus our efforts on the key areas.
3. Evaluation and Testing of Controls	We will evaluate the design effectiveness, and when appropriate, the operating effectiveness of the corporate governance and information technology controls, as well as the controls over each significant activity/process. Based on the result of this evaluation, we will determine the extent of our substantive testing.
4. Substantive Testing	When appropriate, we will use audit software to perform substantive testing. This enables us to retrieve information directly from your data files, if needed, without affecting the integrity of the data.
5. Concluding and Reporting	We will provide management and the Audit Committee with the results of our audit, including best practices and internal control recommendations.



Significant Risks and other areas of focus

The following provides an overview of the areas of significant audit focus based on our risk assessments.

Areas of focus	Procedures
Accounts receivable, related contractual and uncollectable allowances and net patient service revenue	<ul style="list-style-type: none">• Review account reconciliations including completeness and accuracy testing of the aged patient trial balances• Perform analytical procedures over key indicators such as days in accounts receivable, account write offs and aging of balances• Perform detailed account balance testing• Perform cut-off testing• Review management's methodology for estimating allowances• Perform medical record testing for existence (no confirmation procedures) and detail test of subsequent cash receipts• Perform a hindsight analysis of the prior year accounts receivable balance by reviewing cash collections on prior year balances• Perform cash to revenue proof to assist in the validation of the revenue balance
Estimated settlements due to third-party payers and net patient service revenue	<ul style="list-style-type: none">• Review account reconciliations and roll-forwards and agree significant reconciling items to supporting schedules and documentation.• Perform detailed account balance testing• Review management's methodology for estimating amounts• Review the financial statement presentation and disclosures

Significant Risks and other areas of focus (continued)

The following provides an overview of the areas of significant audit focus based on our risk assessments.

Areas of focus	Procedures
Accrued liabilities, reserves, and contingencies	<ul style="list-style-type: none">• Perform detail testing of management's calculations, including underlying inputs and data provided to specialists used in actuarial calculations for workers compensation, pension, OPEB, and self-insurance health liabilities• Obtain and review outside actuarial reports used to determine pension and OPEB liabilities• Assess for reasonableness the assumptions used in developing estimates• Perform a search for unrecorded liabilities• Test the completeness and accuracy of accounts payable aged trial balance• Review payroll accruals for reasonableness

Significant Risks and other areas of focus (continued)

The following provides an overview of the areas of significant audit focus based on our risk assessments.

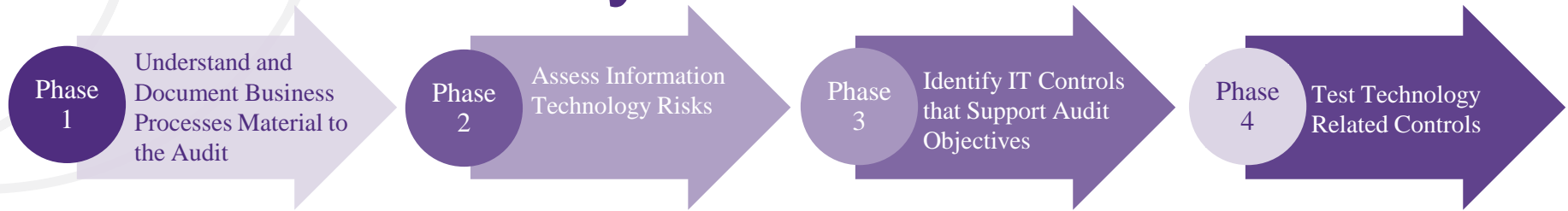
Areas of focus	Planned procedures
Accounting Estimates	The preparation of NYC Health + Hospital's financial statements requires management to make multiple estimates and assumptions that affect the reported amounts of assets and liabilities as well as the amounts presented in certain required disclosures in the notes to those financial statements. The most significant estimates relate to contractual allowances, the allowance for doubtful accounts, third-party liabilities, malpractice liabilities and actuarial estimates for the pension plan. Our procedures have been designed in part, to review these estimates and evaluate their reasonableness.
Financial Statement Disclosures	Our procedures will also include an assessment as to the adequacy of NYC Health + Hospital's financial statement disclosures to ensure they are complete, accurate and appropriately describe the significant accounting policies employed in the preparation of the financial statements and provide a detail of all significant commitments, estimates and concentrations of risk, amongst other relevant disclosures required by accounting standards and industry practice.

Significant Risks and other areas of focus (continued)

Other Areas of Audit Focus

- Perform substantive testing on key account balances as of June 30, 2018, as follows:
 - o Confirmation of cash and cash equivalents.
 - o Test significant fixed asset additions and disposals, as applicable.
 - o Test deferred revenue, as applicable.
 - o Obtain debt rollforward and test payments throughout the year and compliance with debt covenants
 - o Review and testing the completeness of accounts payable and accrued liabilities.
 - o Perform an analytical review of revenues and expenses.
 - o Identify and test non-routine transactions to ensure appropriate accounting treatment.
 - o Independently confirm with internal and external legal counsel the potential exposure associated with outstanding claims, as applicable. Identify contingent liabilities or assets requiring accounting treatment or footnote disclosure.
 - o Perform fraud procedures
 - o Journal entry testing
 - o Review inter-company accounts
 - o Vendor testing

Information Systems Review



Our approach to testing the **Organization's** information technology systems is detailed as follows:

Phase 1: Understand and document business processes material to the audit

Our engagement team will:

- Meet with the **Organization** management to document our understanding of critical business processes and controls, and the technology used to support them.
- Document process flows, controls, and supporting technology relevant to audit objectives.

Phase 2: Assess information technology risks

- Our engagement team will identify information technology related risks and tailor our information technology review procedures to address those risks.

Phase 3: Identify information technology controls that support audit objectives

- General controls review – Review controls applicable to the overall processing environment.
- Applications review – Review specific business systems for application level and related controls.

Phase 4: Test technology related controls

- We will test the identified controls and determine their design and operating effectiveness, within the context of our audit scope and objectives. As a result of our test procedures, we will prepare observations and recommendations to improve existing information technology systems and associated controls and processes.

Other Matters



Required Communication with the Audit Committee

Professional Auditing Standards require us to communicate certain matters to those who have responsibility for oversight of the financial reporting process (the Audit Committee), including the following:

- The auditors' responsibility under U.S. generally accepted auditing standards.
- Significant accounting policies (initial selection thereof and significant changes thereafter).
- Significant management judgments and accounting estimates.
- Significant audit adjustments (recorded and unrecorded) and omitted disclosures.
- Significant disagreements with management.
- The auditors' view about significant matters that management has discussed with other auditors.
- Major issues discussed with management prior to retention.
- Irregularities and illegal acts and material weaknesses or significant deficiencies in the internal control.
- Difficulties encountered in performing the audit.
- Fraud involving senior management or that causes a material misstatement of the combined financial statements

Commitment to Promote Ethical and Professional Excellence

We are committed to promoting ethical and professional excellence. To advance this commitment, we have put in place a phone and Internet-based hotline system.

The Ethics Hotline (1.866.739.4134) provides individuals a means to call and report ethical concerns.

The EthicsPoint URL link

- Can be found on our internal website
- Can be accessed from our external website
(https://secure.ethicspoint.com/domain/en/report_custom.asp?clientid=15191)

Disclaimer: EthicsPoint is not meant to act as a substitute for NYC Health + Hospitals' "whistleblower" obligations.

Our Values are CLEARR

To achieve our global vision, we capitalize on our strengths by embracing the following values:

- Unite through global **Collaboration**
- Demonstrate **Leadership** in all we do
- Promote a consistent culture of **Excellence**
- Act with **Agility**
- Ensure deep **Respect** for people
- Take **Responsibility** for our actions

Our values serve as the foundation of each step we take toward achieving our vision. They guide our decision-making and provide a framework for our people to make correct and appropriate choices.



Technical Updates - GASB



Selected pronouncements effective for the year ending June 30, 2018 or subsequent periods - GASB

Title	Effective fiscal year ending
<i>GASB 83- Certain Asset Retirement Obligations</i>	June 30, 2019 *
<i>GASB 84- Fiduciary Activities</i>	June 30, 2020
<i>GASB 85- Omnibus 2017</i>	June 30, 2018
<i>GASB 86- Certain Debt Extinguishment Issues</i>	June 30, 2018
<i>GASB 87- Leases</i>	June 30, 2021
<i>GASB 88- Certain Disclosures Related to Debt, including Direct Borrowing and Direct Placements</i>	June 30, 2019

* NYC Comptroller's office is requesting early adoption for June 30, 2018

GASB Statement 83, *Certain Asset Retirement Obligations*

Summary	Potential impact
<ul style="list-style-type: none">• Objective is to develop requirements on recognition and measurement for asset retirement obligations (ARO), other than landfills (GASB 18) or pollution remediation obligations (GASB 49), such as nuclear power plants and sewage treatment facilities• The pronouncement addresses the following:<ul style="list-style-type: none">- Establishes criteria for determining the timing and pattern of recognition of a liability and a corresponding deferred outflow of resources when a governmental entity has a legal obligation to perform future asset retirement activities related to its tangible capital assets- Proposes capitalization of the ARO as a deferred outflow of resources, to be amortized in a systematic and rational manner (such as the straight-line method), generally over the life of the related asset giving rise to the obligation- Requires disclosures regarding governmental entity legal requirements to provide funding or other financial assurance for their performance of asset retirement obligations (e.g., how are those requirements being met) as well as nature and timing of AROs, method used to determine the estimated liability and useful life of the associated tangible asset.• Effective for periods beginning after June 15, 2018. Earlier application is encouraged.	<p>Similar to the efforts organizations underwent when adopting GASB 49, management should inventory any activity whereby there is a related obligation to dispose of certain assets subject to regulatory and legal requirements. With that list, management must calculate the expense of that effort and track it annually. The effort to inventory these assets/costs may require input from facilities and potentially other areas of the Organization and the process to estimate costs of future events may also require assistance from facilities and other departments.</p>

GASB Statement 84, *Fiduciary Activities*

Summary	Potential impact
<ul style="list-style-type: none">• Guidance addresses the following:<ul style="list-style-type: none">- The categorization of fiduciary activities for financial reporting- How fiduciary activities are to be reported- When liabilities to beneficiaries must be disclosed• Types of fiduciary funds that must be reported include the following:<ul style="list-style-type: none">- Pension (and other employee benefit) trust funds- Investment trust funds- Private-purpose trust funds- Custodial funds• A government controls the assets of an activity if it holds the assets or "has the ability to direct the use, exchange or employment of the assets in a manner that provides benefits to the specified or intended recipients"• Fiduciary activities must be disclosed in the basic financial statements of the government entity and a statement of fiduciary net position and changes in fiduciary net position should be presented (unless the period of custody is less than three months).• Effective for periods beginning after December 31, 2018, with early adoption encouraged.	<p>Organizations often will agree to act as a fiduciary for certain third party entities that might be somehow affiliated to the organization. Under this new requirement, the Organization must report the fiduciary activity on its financial statements, where it may not have done so in the past. Management should identify which fiduciary activities it is engaged in to inventory the relationships which may need to be reported. Management may want to consider changing the terms of the relationships such that they are not subject to reporting on the financial statements of the Organization when the requirement becomes effective.</p>

GASB Statement 86, *Certain Debt Extinguishment Issues*

Summary	Potential impact
<ul style="list-style-type: none">• The purpose of this guidance is to achieve consistency regarding accounting for the defeasance of debt irrespective of the source of funds set aside in an irrevocable trust for the purpose of funding the remaining debt (source of funds could be proceeds from a refunding arrangement or existing sources within the governmental entity).• New guidance clarifies the accounting for debt extinguishment when the source of the assets to be set aside in an irrevocable trust is existing resources rather than refund proceeds. When all of the other criteria for in-substance defeasance are in place, the debt is removed from the statement of net position and is disclosed in the footnotes in either scenario.• GASB 86 also requires that any remaining prepaid insurance related to the debt being extinguished must be included in the net carrying amount of that debt (to determine gain or loss on refunding).• Disclosures include a description of the transaction in the related period and remaining amounts outstanding in each subsequent period that the debt remains outstanding.• Effective for periods beginning after June 15, 2017, with early adoption encouraged. Changes to adopt this standard should be applied retroactively.	<p>Depending on how organizations fund the irrevocable trust related to debt extinguishments, the new standard may create additional situations where debt will be "removed" from the statement of net position, and disclosed in the footnotes to the financial statements. For organizations considering future refundings, there is no longer a distinction in the accounting if the source of funds to be placed in an irrevocable trust are from existing resources or refunding arrangements.</p>

GASB Statement 87, *Leases*

Summary

- The GASB recently issued guidance which resembles the recently issued FASB guidance on leases.
- To determine whether a lease exists, a government should assess whether it has both:
 - 1) The right to obtain the present service capacity from use of the underlying asset as specified in the contract, and
 - 2) The right to determine the nature and manner of use of the underlying asset as specified in the contract
- For Lessees:
 - In general, all leases will be reported on the statement of net position (the distinction between operating and capital leases is no longer relevant) as a "right of use" asset and a corresponding lease liability within long term debt
 - On the statement of changes, rent expense will be replaced by amortization expense of the right-of-use asset as well as interest expense on the lease liability (thus accelerating expenses in the beginning years of the lease term)
 - There is an exemption for short term leases (those with a term of 12 months or less, including extension options) as well as leases that transfer ownership at the end of the term
 - Disclosures regarding matters such as total leased assets by major class of underlying assets and related accumulated amortization (in total), principal and interest payments for each of the five subsequent fiscal years and in five year increments thereafter and commitments under leases before a lease commencement period, among other items
- Effective for periods beginning after December 15, 2019, with early adoption encouraged. Existing leases will be adjusted based on the remaining lease payments as of the beginning of the period of adoption or beginning of any earlier periods restated (for example, for June 30 year ends, adoption is June 30, 2021 so the beginning period is July 1, 2020).

GASB Statement 87, *Leases* (continued)

Potential Impact

For those organizations which use operating leases to finance certain capital activities, this standard could have a significant impact on the financial statements of the organization upon adoption. Management should consider the impact on financial covenants, as well as ensuring a complete inventory of existing leases that will be subject to the new accounting and disclosures.

GASB Statement 88, Certain disclosures related to debt, including direct borrowings and direct placements

Summary

- The primary objective of this Statement is to improve the information that is disclosed in notes to government financial statements related to debt, including direct borrowings and direct placements. It also clarifies which liabilities governments should include when disclosing information related to debt.
- This Statement defines debt for purposes of disclosure in notes to financial statements as a liability that arises from a contractual obligation to pay cash (or other assets that may be used in lieu of cash) in one or more payments to settle an amount that is fixed at the date the contractual obligation is established.
- This Statement requires that additional essential information related to debt be disclosed in notes to financial statements, including unused lines of credit; assets pledged as collateral for the debt; and terms specified in debt agreements related to significant events of default with finance-related consequences, significant termination events with finance-related consequences, and significant subjective acceleration clauses.
- For notes to financial statements related to debt, this Statement also requires that existing and additional information be provided for direct borrowings and direct placements of debt separately from other debt.
- Effective for periods beginning after June 15, 2018, with early adoption encouraged.

GASB projects

Project	Timing
Financial Reporting Model- Reexamination of Statements 34, 35, 37, 41 and 46, and Interpretation 6	Evaluation of feedback from Invitation to Comment in process, planned issuance of final standard in 2022.
Revenue and expense recognition	Initial deliberations, with an Invitation to Comment expected in early 2018.
Recognition (conceptual framework)	GASB is redeliberating on results from comments on preliminary views
Capitalization of Interest Costs	Exposure draft available for comment through March 2018, with a final statement expected in June 2018
Conduit Debt- Reexamination of Interpretation 2	Recently added to the agenda
Equity Interest Ownership Issues	Exposure Draft comment period recently ended, currently in redeliberations, with final statement expected August 2018
Implementation Guide- GASB 84 (Fiduciary Activities)	Material for Guide in development, final Guide expected to be available in May 2019
Implementation Guide- GASB 87 (Leases)	Material for Guide in development, no current date for release is available

GASB major project – Financial Reporting Model

Summary	Potential impact
<ul style="list-style-type: none">• GASB is revisiting its reporting model established in GASB 34 and 35, as well as other GASB standards, following the FASB project to revisit the reporting model of NFP entities.• Although there is general consensus that most of the components of the financial reporting model are effective, the Board determined that there is a need to update guidance related to several categories, focusing on the following:<ul style="list-style-type: none">- MD&A- Government-wide financial statements- Major funds- Governmental fund financial statements- Proprietary fund and business-type activity financial statements- Fiduciary fund financial statements- Budgetary comparisons• Other options to permit more timely and less complex financial reporting will be explored in conjunction with other topics• The Board is redeliberating based on feedback from invitation to comment and public meetings. Tentative timing for issuance of final guidance is projected to occur in 2022.	<p>Similar to the significant impact on reporting and disclosures when GASB 34 and 35 were issued, this proposed guidance could have sweeping effects on the reporting and disclosures. Depending on how much the GASB looks to what is being done by the FASB on the NFP reporting model, there could be an increase in comparability between the two types of entities that currently use very different reporting models.</p>

GASB major project – Revenue and Expense Recognition

Summary	Potential impact
<ul style="list-style-type: none"> Three primary areas of focus of the project are as follows: <ol style="list-style-type: none"> Common exchange transactions not specifically addressed in existing GASB guidance <ul style="list-style-type: none"> Project plans to develop guidance or improve existing guidance regarding <ol style="list-style-type: none"> Exchange and exchange-like transactions having single elements Exchange and exchange-like transactions having multiple elements The differentiation between exchange-like and non-exchange transactions Post-implementation review of GASB 33 and 36 <ul style="list-style-type: none"> Areas to be considered include: <ol style="list-style-type: none"> Distinguishing between eligibility requirements and purpose restrictions Determining when a transaction is an exchange or a nonexchange transaction Using the availability period concept consistently across governments Applying time and contingency requirements Development of GASB conceptual framework <ul style="list-style-type: none"> GASB 33 and 36 were developed prior to key parts of the conceptual framework, such as defining deferred inflows and outflows An evaluation of the recognition of nonexchange transactions against the conceptual framework is necessary Invitation to Comment has been issued, with a comment period through April 2018. Current projected release of a final statement is March 2023. 	<p>As it relates to recognition of exchange and nonexchange transactions such as grants vs gifts vs contracts, there continues to be an element of judgment and interpretation of existing GASB and FASB guidance. This project could impact the current practices of health care institutions as it relates to revenue recognition.</p>

GASB pre-agenda research

Topics

- Going concern disclosures
- Information technology arrangements, including cloud computing
- Note disclosures reexamination
- Public-private partnerships, including reexamination of Statement 60

This communication is intended solely for the information and use of management and the Audit Committee of NYC Health + Hospitals and is not intended to be and should not be used by anyone other than these specified parties.



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OFFICE OF INTERNAL AUDITS

**AUDIT COMMITTEE BRIEFING
JUNE 2018**

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A. EXTERNAL AUDITS

1. Controls Over Equipment – Office of the State Comptroller

Audit Notification Letter Received – December 5, 2017

Entrance Conference – December 20, 2017

Audit Status – In Progress

The Office of the State Comptroller commenced their audit of Controls over Equipment on the day of the entrance conference. The following items were requested:

1. *HHC's most current certified audit report.*
2. *Supporting documentation, including a listing of specific equipment, for the amount reported as equipment in HHC's latest certified financial statements.*
3. *A listing of vehicles, if any, included in the financial statements.*
4. *Any internal and external audit reports which dealt with the adequacy of HHC's equipment controls.*
5. *Internal Control Certifications.*
6. *Policies and procedures related to equipment disposal.*
7. *A current organization chart of the unit which deals with equipment, including contact information.*
8. *Any known instances of fraud and actions taken.*

After meeting with Corporate Finance, the Auditors visited NYC Health + Hospitals/Bellevue to review their processes related to equipment. They also met with EITS and Corporate Operations to discuss their controls in effect over their equipment procurement and maintenance processes.

Their testing began on January 23, 2018. As of May 21, 2018, testing has been conducted at 8 facilities:

- NYC Health + Hospitals/Bellevue
- NYC Health + Hospitals/Elmhurst
- NYC Health + Hospitals/Jacobi
- NYC Health + Hospitals/Harlem
- NYC Health + Hospitals/Gotham Health, East New York
- NYC Health + Hospitals/Gotham Health, Belvis
- NYC Health + Hospitals/Gotham Health, Roberto Clemente
- NYC Health + Hospitals/Gotham Health, South Queens

The objective of the audit appears to include a physical verification of assets, and the review of the Fixed Asset System and asset disposal procedures.

B. COMPLETED AUDITS**1. *System-wide Review of Leased & Owned Vehicles (Final Report Issued 5/14/18)***

As of the calendar year-end 2017, 447 vehicles were owned or leased by NYC Health + Hospitals system wide. A breakdown of the number of vehicles and the function responsible for their oversight are as follows:

Transportation Departments at Facilities:	325
Central Office Transportation Department:	87
Inspector General/Department of Investigation:	35

The majority of the vehicles monitored by Central Office are leased as Corporate Budget has determined that leasing is the more fiscally responsible approach over purchasing vehicles. In contrast, almost all of the vehicles utilized at the facilities have been purchased.

The Inspector General requested that Central Office purchase their cars because specialized equipment, such as radios and sirens, needed to be installed and this could not be done with leased vehicles. 30 of the 35 vehicles were purchased in late 2016 and 2017.

Our review revealed that the systems and processes in effect for the vehicles that Central Office Transportation oversees are efficient and organized and should be adopted at the facilities. While we found that the fuel and EZ Pass usage were well controlled at the facilities, there were some areas of improvement needed. It is because of these deficiencies and the reasons discussed below that we recommend that control over the vehicles system-wide be centralized and that policies and procedures be standardized.

a) No Centralized Procurement

Vehicles are purchased from numerous vendors. A review of eight of the facilities revealed that their vehicles were purchased from 46 different car dealers.

b) Excessive Number of Vehicles

Of the 325 vehicles at the facilities, 193 are used to transport patients and administrative staff; the other 132 are used for maintenance or by specific departments such as Hospital Police and Behavioral Health.

Although there are 193 vehicles used by the facility Transportation Departments, there are only 121 Motor Vehicle Operators (MVO) employed throughout the facilities. The reason for the abundance of vehicles is that the vehicles are purchased, and when they are no longer needed, they are kept in the fleet.

c) Use of Non-Contracted Repair Shops

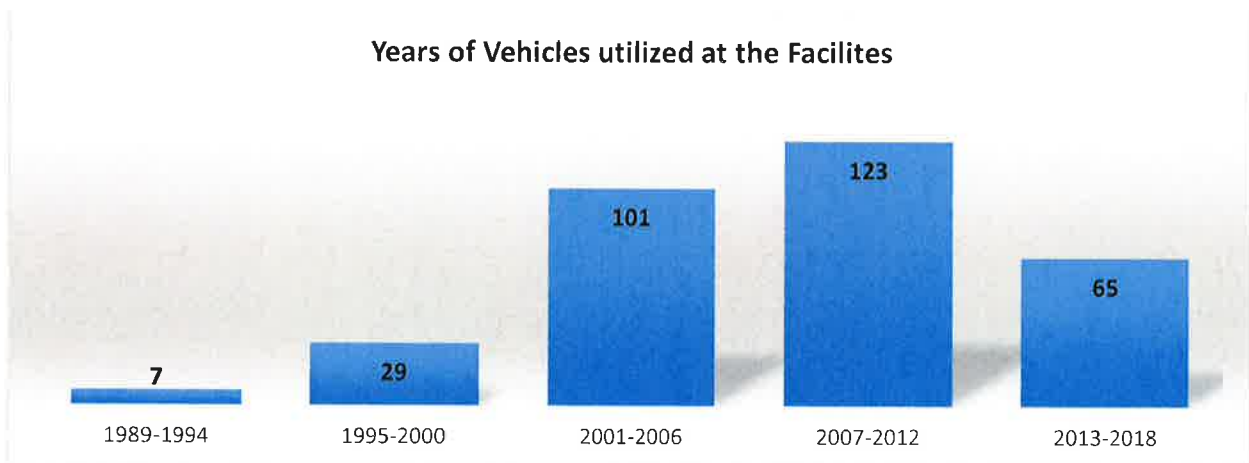
The Central Office Transportation Department (and Correctional Health) utilizes a Global Fleet Management Service (ARI) contracted by the NYC Department of Citywide Administrative Service (DCAS) to manage the preventive maintenance of their fleet. ARI offers an open network with access to over 600 repair vendors within the five boroughs. As part of their service, ARI Technicians scrutinize each requested repair and parts and labor for accuracy and cost savings.

The facilities are not using ARI for vehicle maintenance to reduce the risk of inflated prices for parts and labor. Instead, the facilities are using outside vendors that do not always have contracted prices. In addition, some facilities are using mechanics that are not in close proximity to their sites. For example, Queens and Harlem use repair shops located in Brooklyn.

d) Most Facility Vehicles Are Older in Years

There are 260 vehicles, purchased from 1989 to 2012, that are utilized at the facilities (see the table below for a breakdown of the age of the vehicles). This has also added to the problem of excessive maintenance expenses. For example, during FY17, NYC Health + Hospitals/Coler spent \$85,000 for maintenance for their 17 vehicles purchased from 1999 – 2012.

In addition, there are vehicles at the facilities that are not being utilized due to reoccurring maintenance expenses and have not been relinquished. For example, at Kings County Hospital, an RV has been stationed and not utilized since 2012.



e) Inconsistent Disposal of Vehicles

As previously mentioned, vehicles are not being disposed of properly or timely. The unwritten policy to dispose of vehicles is to have them sent to Sea View who in turn forwards them to DCAS for disposal. This is not always followed as it was observed that vehicles are parked in the facilities that have not been utilized for years (see pictures below for examples).

Vehicles not being utilized at the facilities



2003 Chevrolet @ Coler



2000 Chevy Cushman @QHC



2005 Freight RV @KCH



2006 Ford @Jacobi Hospital

f) Outdated Policies and Procedures

The current Automobile Policy (OP 170-2) was established in September 1997. It does not reflect the operations currently practiced within Central Office Transportation. In addition, the policy does not address the:

- Personnel permitted to be assigned a vehicle for personal and business use.
- Justification in determining when a new vehicle is needed.
- Approval process as it relates to the purchase or leasing of a vehicle.

- Maintenance and disposal of vehicles.

The Vice President of Corporate Operations responded that Central Office Transportation will take the lead in updating OP 170-2.

g) Oversight of Placards Needs Improvement

During our review of Parking Placards and privileges, we noted that 5 placards on the Central Office Transportation listing of 140 could not be found at the facilities. We recommended that the Central Office Transportation Department should review the placards listing with the Fleet Managers at the facilities on a quarterly basis. The Vice President of Corporate Operations responded that the placards will be incorporated into their quarterly review with each facility.

Overall Summary

In response to the recommendation to centralize oversight of all system-wide vehicles and to lease vehicles rather than purchasing them, the Vice President of Corporate Budget stated that they are committed to working closely with Central Office Transportation and Supply Chain on supporting any financial analytics needed to standardize processes and to determine the most cost-effective approach to acquiring and utilizing vehicles across NYC Health + Hospitals.

The Vice President of Supply Chain Services responded that his area will implement leasing as the preferred method of procurement for New York City Health + Hospitals vehicles and will only utilize the purchasing methodology when specific funding rules require it. The Vice President of Operations responded that Central Office Transportation will assist the system facilities regarding the best practices in place at Central Office.

2. Volunteer Services - Kings County (Final Report Issued 2/8/18)

The objectives of the audit were to evaluate the internal controls over the management of Volunteer Services. The following audit observations were noted:

- a) During our review of background checks of 68 volunteers, we found:
- The Volunteer Services Department authorized 12 volunteers to begin working 3 to 77 days prior to obtaining the results of a State Central Register of Child Abuse search which is required for those individuals working in areas with pediatrics or behavioral health patients. This Child Abuse search was not conducted at all for 2 other volunteers, who have been active since October 2015 and April 2016.
 - There was no proof of identification, such as a copy of a passport or license, within the personnel files for 3 volunteers.

The Director in charge of the Volunteer Services Department responded that a tracking and notification process would be created to ensure background searches are conducted prior to assigning volunteers to the Pediatric and/or Behavioral Health Services and that all checks will include identity verification.

- b) System access was not disabled for all inactive volunteers. We found 14 inactive volunteers had an enabled Active Directory account and 11 inactive volunteers with an active QuadraMed (Medical Record System) account.

Two of the inactive volunteers successfully logged into the Active Directory after their end date. The Office of Corporate Compliance informed us that 1 of the 2 volunteers also logged into QuadraMed after her end date. As a result, her account has been subsequently disabled. They concluded that a violation certainly occurred where another's account was used, but a breach could not be determined.

The Director in charge of the Volunteer Services Department responded that all identified volunteers have been deactivated. In addition, the current separation process in place for Health + Hospitals employees will be implemented. Lastly, periodic system access will be conducted to identify volunteers who are not active.

- c) The Behavioral Health Department uses pre-signed blank access request forms titled "Network System Access Request Form" and "QuadraMed Access Form", with the Chief of Behavioral Health's signature. To obtain QuadraMed access, volunteers are given the pre-signed system access request forms to submit to the IT/Patient Accounts Department, creating the opportunity for it to be altered after it has been authorized. Both of the aforementioned forms do not explicitly indicate what level of access is being requested for each system (e.g. review only, edit etc.).

The Chief of Behavioral Health responded that, going forward, System Access Request Forms will be completed by the volunteer prior to obtaining the signature of the Chief of Service.

d) Controls over the retrieval of Identification (ID) Cards of volunteers when they end their service was inadequate. We noted:

- The ID cards for 12 volunteers, who had access to the Medical/Surgical, Pediatrics and Behavioral Health areas, were still active 112 to 646 days after their separation date.
- One of the ID cards was used to swipe in 2,106 times during the 6 month period after the volunteer's separation date. Hospital Police later determined that the volunteer's supervisor had retrieved the card and was using it in error to enter and exit 31 different areas within the facility.
- The personnel records in the Volunteer Office for 2 volunteers showed that they were no longer active. However, when it was brought to their attention that their ID cards were still being swiped, it was determined that they were still actively volunteering.

The Director in charge of the Volunteer Services Department responded that they would incorporate the current separation process in place for Health + Hospitals employees into the process being used for volunteers. In addition, periodic reviews of the database will be conducted to identify inactive volunteers.

e) The personnel information of the volunteers was not properly input to the PeopleSoft Human Resources database. When comparing the PeopleSoft database to the internal volunteer database, the following discrepancies were observed:

- 67 volunteers were not entered into PeopleSoft
- 62 inactive volunteers were classified as "active" in PeopleSoft
- 38 names in their database did not match PeopleSoft records

The Director in charge of the Volunteer Services Department responded that a monthly reconciliation will be performed between PeopleSoft and the Volunteer Services Department database.



**AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
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Audit Committee Report

Corporate Compliance Report

June 13, 2018



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BOARD OF DIRECTORS**
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
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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 April 1, 2018 through May 31, 2018

4) During the period April 1, 2018 through May 31, 2018, there was one disciplined provider identified through the OCC’s monthly sanction screening. On April 4, 2018, the OCC was informed that a Physician Affiliate Group of New York (“PAGNY”)-affiliated physician at NYC Health + Hospitals/Harlem (“Harlem”) had limitations placed on his license effective March 21, 2018. These limitations preclude the physician from prescribing controlled substances (except those medications listed in Exhibit C of the Board of Professional Misconduct Consent Order #18-056) until the physician successfully completes a Clinical Competency Assessment, and include a restriction to only practice medicine when the physician is being monitored by a licensed, board certified physician during the period of probation. On April 4, 2018, the OCC informed PAGNY of the restrictions on the physician’s license. The OCC also confirmed that the Office of Legal Affairs and Dr. Wright, Chief Medical Officer at Harlem, were aware of the physician’s restrictions, and Dr. Wright informed the OCC that he was awaiting a decision from the medical board at Harlem regarding the possible omission of vital information during the physician’s reappointment application. The physician has not violated any restrictions on his license, and has not furnished services at Harlem since the probation period started; nor is the physician currently working at Harlem. 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

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)”).

both require screening of the System’s workforce members, certain business partners, and agents (collectively “Covered Persons”) to ensure that none of these Covered Persons are using the social security number (“SSN”) or National Provider Identifier (“NPI”) number of a deceased person in an effort to hide their true identity. This screening may be accomplished by vetting the SSNs and NPIs of Covered Persons through the Social Security Administration Death Master File (“DMF”) and the National Plan and Provider Enumeration System (“NPES”), respectively.

6) The OCC currently screens the DMF and NPES files regularly as part of its sanction screening process. No providers have been identified on the DMF or NPES during the period April 1, 2018 through May 31, 2018.

II Privacy Incidents and Related Reports

Reportable Privacy Incidents for the period of April 1, 2018 through May 31, 2018

7) During the period of April 1, 2018 through May 31, 2018, twenty (20) privacy complaints were entered into the ID Experts RADAR Incident Tracking System. Of the twenty (20) complaints entered in the tracking system, six (6) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures (“OPs”), specifically OP 240-15 HIPAA Privacy Safeguards Policy, and OP 240-28 HIPAA Policy on Uses and Disclosures for Treatment, Payment and Healthcare Operations; five (5) were determined to be unsubstantiated; five (5) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures; three (3) are still under investigation; and one (1) was only a request for guidance. Of the six (6) incidents confirmed as violations, three (3) 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

⁷ See 45 CFR § 164.402.

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 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 for the Period of April 1, 2018 through May 31, 2018

11) As stated above, there were three (3) reportable breaches between April 1, 2018 and May 31, 2018. Below is a summary of those breaches:

- **NYC Health + Hospitals/Coney (“Coney”) – April 2018**

Incident: This incident was brought to our attention on April 7, 2018, and occurred when laboratory specimens for five (5) patients went missing, and were unable to be located. The PHI on the specimen containers was limited to the patient name, medical record number, date of birth, specimen source and collection date.

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).

Breach Determination: Of the four key factors described 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, notifications were sent to the affected individuals on May 17, 2018.

Mitigation: In response to this incident, Coney has added new procedures to transport and log specimens to and from the laboratory to better track the movement of specimens. In addition, workforce members were retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information.

- **NYC Health + Hospitals/Lincoln (“Lincoln”) – April 2018**

Incident: This incident was discovered on April 13, 2018, and occurred when a patient mistakenly was given discharge papers belonging to another patient. The PHI on the papers included information such as patient name and medical record number, medical diagnosis pertaining to substance use, and discharge instructions.

Breach Determination: Of the four key factors described 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 May 16, 2018.

Mitigation: The discharge papers were promptly returned to Lincoln. In response to this incident, workforce members involved were retrained on HIPAA policies and procedures as they relate to maintaining the confidentiality of patient information. Workforce members were also reminded to validate the identity of the patient before handing them any PHI.

- **NYC Health + Hospitals/Bellevue (“Bellevue”) – May 2018**

Incident: This incident was brought to our attention on May 15, 2018, via a 311 call from a patient who mistakenly received documentation containing another patient’s information. After an investigation into the incident, it was determined that the PHI on the document included information such as patient’s name, date of birth, medical record

number, and address. Attempts to contact this patient to return the documents were unsuccessful.

Breach Determination: Of the four key factors described 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 May 30, 2018.

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

OCR Inquiries Regarding Potential and/or Determined Privacy Incidents

12) There was one inquiry initiated by the Office for Civil Rights (“OCR”) since April 1, 2018. The inquiry pertained to the incident which occurred at NYC Health + Hospitals/Harlem (“Harlem”) which was reported at the April 2018 Audit Committee meeting. The incident involved a stolen laptop from the Audiology department at Harlem, and affected over 500 patients. The OCR inquiry included a request for additional information about the breach, including the short-term and long-term remediation actions taken post-incident, and copies of the System’s HIPAA privacy and security policies and procedures and other internal controls documentation. The OCC submitted its response to the OCR’s inquiry on May 29, 2018.

Update on Policy for Securing Biomedical Devices

13) As reported at the April 2018 Audit Committee meeting, there was a breach of PHI at Harlem that resulted from the theft of a laptop from the Audiology Department. During the discussion regarding this breach, the OCC reported that it would be working with Enterprise Information Technology Systems (“EITS”) to develop a policy and procedure for documenting and securing biomedical devices that enter the System and connect to the System’s network, as well as devices that do not connect to the System’s network. The OCC and EITS are currently working on such a policy, and expect to have it completed before the next Audit Committee meeting.



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III Compliance Reports

Summary of Reports for the Period of April 1, 2018 through May 31, 2018

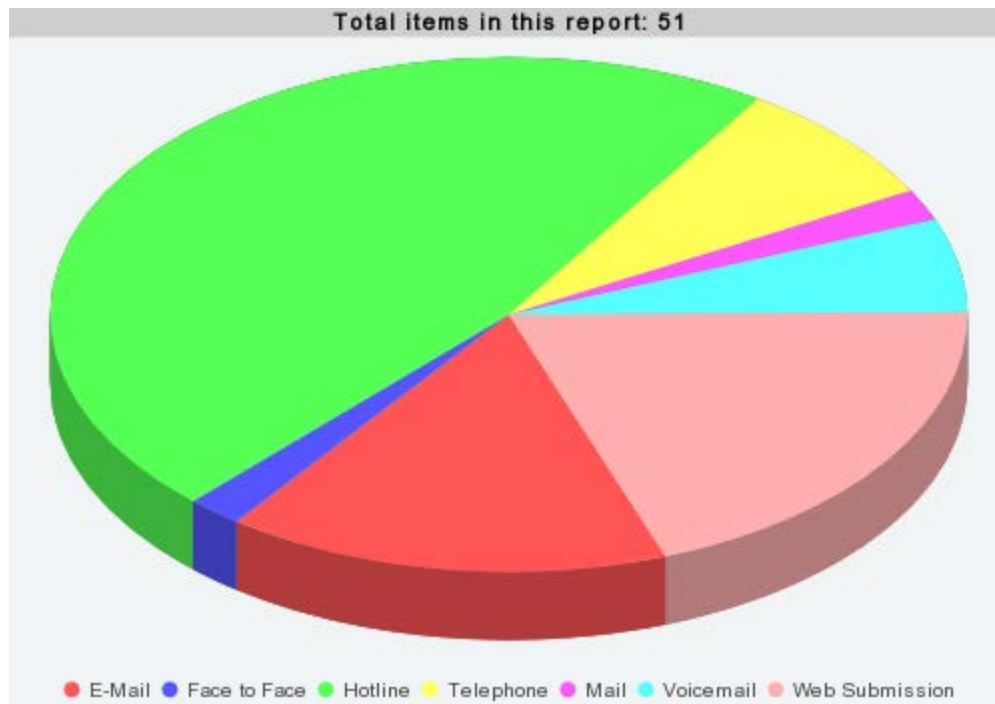
14) For the period April 1, 2018 through May 31, 2018, there were fifty-one (51) compliance reports, none of which were classified as a Priority “A”;¹⁰ thirteen (13) (25.5%) were classified as Priority “B”; and thirty-eight (38) (74.5%) were classified as Priority “C” reports. For purposes here, the term “reports” means compliance-based inquiries and compliance-based complaints. The fifty-one (51) reports were received from the below-listed sources:

a. PRIMARY ALLEGATION SOURCES

SOURCE

	Total	Frequency (Percentage)
E-Mail	8	15.7
Face to Face	1	2
Hotline	24	47.1
Telephone	4	7.8
Mail	1	2
Voicemail	3	5.9
Web Submission	10	19.6
Total	51	100

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.

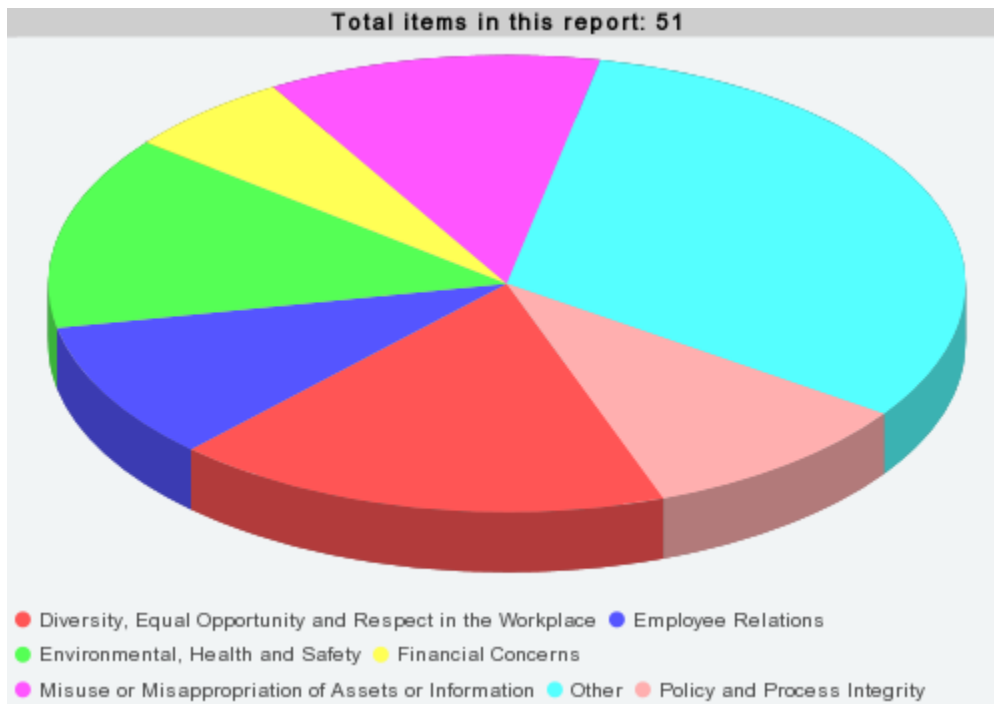


b. PRIMARY ALLEGATION CLASS

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

PRIMARY ALLEGATION CLASS

	Total	Frequency (Percentage)
Diversity, Equal Opportunity and Respect in the Workplace	9	17.6
Employee Relations	5	9.8
Environmental, Health and Safety	7	13.7
Financial Concerns	3	5.9
Misuse or Misappropriation of Assets or Information	6	11.8
Other	16	31.4
Policy and Process Integrity	5	9.8
Total	51	100

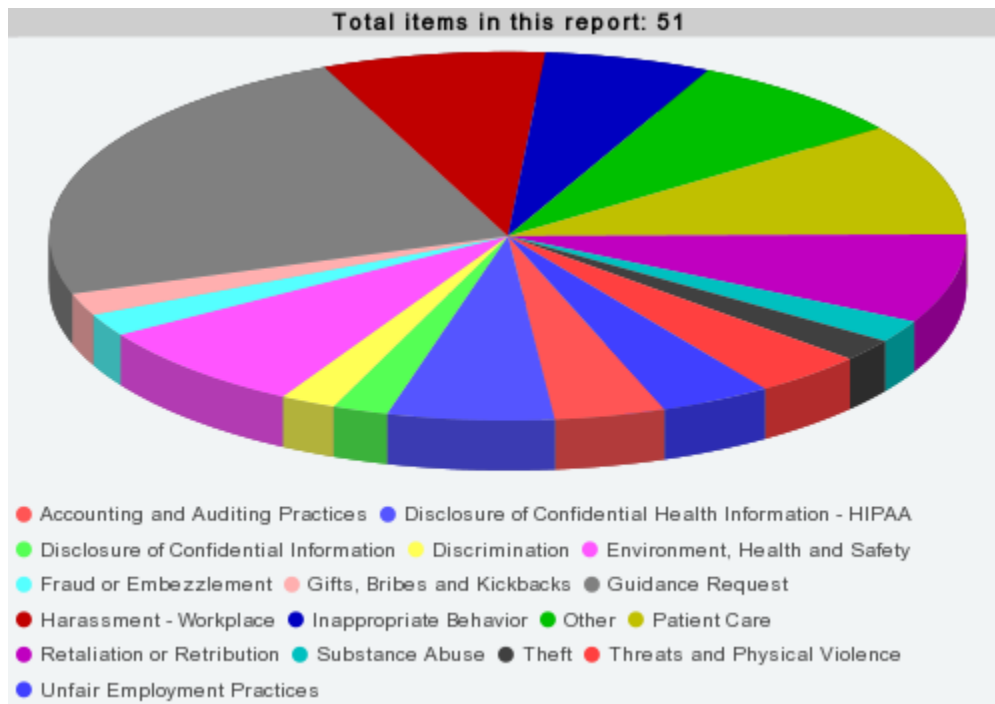


c. PRIMARY ALLEGATION TYPE

PRIMARY ALLEGATION TYPE

	Total	Frequency (Percentage)
Accounting and Auditing Practices	2	3.9
Disclosure of Confidential Health Information - HIPAA	3	5.9
Disclosure of Confidential Information	1	2
Discrimination	1	2
Environment, Health and Safety	4	7.8
Fraud or Embezzlement	1	2
Gifts, Bribes and Kickbacks	1	2
Guidance Request	12	23.5
Harassment - Workplace	4	7.8
Inappropriate Behavior	3	5.9
Other	4	7.8
Patient Care	5	9.8

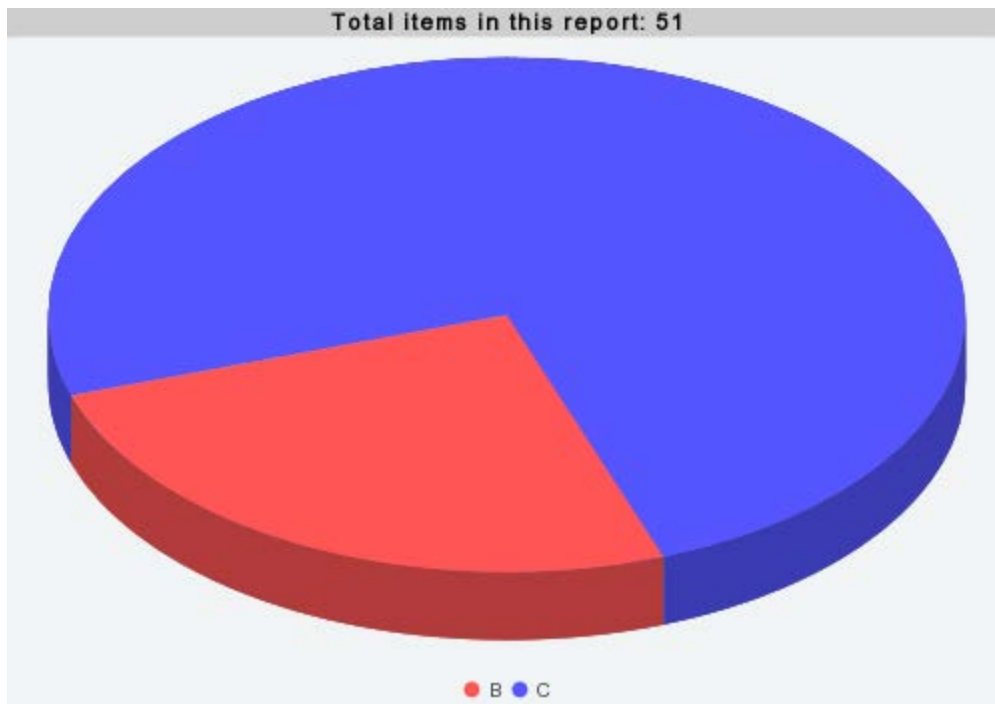
Retaliation or Retribution	4	7.8
Substance Abuse	1	2
Theft	1	2
Threats and Physical Violence	2	3.9
Unfair Employment Practices	2	3.9
Total	51	100



d. PRIORITY CLASSIFICATION

PRIORITY

	Total	Frequency (Percentage)
B	13	25.5
C	38	74.5
Total	51	100



IV. Review and Updating of Compliance Policies and Procedures

Current Operating Procedure Reviews

15) 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 summer:

- 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); and



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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).

In addition, OP 50-6 (Emergency Medical Treatment and Active Labor Act (“EMTALA”)), was finalized has been presented to the President for his signature.

Upcoming OP Reviews

16) 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

17) 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.

18) As reported to the Audit Committee in April 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 providers’ program integrity systems when dedicating resources and developing the PPS

¹¹ 18 NYCRR §521.3(c)(3); *see* 18 NYCRR § 521.1; Social Services Law § 363-d (2)(c).

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 survey, which is designed to assess its performing providers' ("Partners") compliance with the program requirements.

OneCity Health Compliance Attestation

19) 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") survey 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.

20) 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

21) 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.

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

23) 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.

24) 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.

25) 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

26) 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

27) 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

28) 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 about:¹⁵
 - 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 organization's employees to be protected as whistleblowers; and
 - A specific discussion of the provider organization's policies and procedures for detecting fraud, waste and abuse.

29) 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.*



**AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS**
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
June 13, 2018 @ 11:00 AM

Total Number of Attestations Completed and Returned to OneCity Health

30) To date, of the one hundred sixty-eight (168) OneCity Health Partners who executed a Schedule B for Phase III, seventy-seven (77) Partners have 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

31) As reported at the April 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. The committee voted in favor of the vendor Bonadio, which has extensive experience in this area. Bonadio has begun its audit of OneCity Health, and has provided a list of documents for OneCity Health to submit for the audit. Last Friday, June 8, 2018, Bonadio conducted a full-day walkthrough of OneCity Health, which covered OneCity Health’s internal processes, including Partner selection and contracting, quarterly reporting, funds flow, and the Partner portal. The audit is expected to be completed in October 2018.

VI. Status Update - HHC ACO, Inc.

Background of HHC ACO, Inc.

32) 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.

HHC ACO Application for New York State ACO Certificate of Authority

33) As reported at the April 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. 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

34) As reported at the April 2018 Audit Committee meeting, 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 and 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 it contracts with, such as the System, meet their compliance program obligations. These reviews are conducted under the auspices of their “Delegated Vendor Oversight” responsibilities, as required by CMS.

35) 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.

36) 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.

37) On April 16, 2018, the OCC received a draft of Aetna's review of the OCC's document submissions and its conclusions based thereon. According to the draft review, Aetna concluded that NYC Health + Hospitals passed three of the compliance requirements, and failed nine of the requirements. During a conference call with Aetna auditors, however, the OCC presented verification for five of the requirements that Aetna had concluded were failed, prompting Aetna to conclude that NYC Health + Hospitals passed those requirements.

38) On April 30, 2018, the OCC received Aetna's Notice of Compliance Program Audit (the "Audit Report"), which included Aetna's final conclusions regarding NYC Health + Hospitals' compliance with its audit. According to the Audit Report, NYC Health + Hospitals satisfied eight of the compliance requirements, but failed to satisfy four compliance requirements. The Audit Report also required NYC Health + Hospitals to submit to Aetna corrective action plans for the failed compliance requirements, which the OCC did on May 25, 2018. NYC Health + Hospitals has ninety (90) days to implement these corrective actions plans, most of which involve changes to Operating Procedures.

VIII. Fiscal Year 2018 Corporate-wide Risk Assessment

Regulatory Requirements

39) The fiscal year 2018 (“FY2018”) Corporate-wide Risk Assessment (the “Risk Assessment”) outlines the ongoing process implemented by the OCC to create the fiscal year 2019 (“FY2019”) NYC Health + Hospitals Corporate Compliance Work Plan (“FY2019 Work Plan”). The risks identified in the Risk Assessment will be analyzed and prioritized to determine which risks pose the greatest threats to the System. This process will result in the FY2019 Work Plan, which will identify such risks and explain how the System will address them.

40) The Risk Assessment is undertaken pursuant to NYS Social Services Law (“SSL”) § 363-d(2)(f) and its implementing regulation found at 18 NYCRR § 521.3(c)(6), which require the establishment of a system for routine identification of compliance risk areas. The Risk Assessment is also a component of the System’s OP 50-1, *Corporate Compliance and Ethics Program*, which is centered on promoting the prevention, detection, and mitigation of fraud, waste, and abuse, as well as other unprofessional or criminal conduct, and ensuring the System’s compliance with city, State and Federal laws, rules, and regulations, and its own business and ethical standards of practice.

41) In addition, OP 50-1 provides that the Chief Corporate Compliance Officer (“CCO”) shall have primary responsibility for performing System-wide risk identification, assessment, and prioritization activities, and presenting the findings and the resulting Corporate Compliance Work Plan to the President and Audit Committee of the NYC Health + Hospitals Board of Directors for risk appetite determinations. This includes conducting annual risk assessments at the facility, unit, entity, and program levels, and selecting identified items for inclusion and implementation in the Corporate Compliance Work Plan.

The Risk Assessment Process

42) The OCC has identified various risks to the System, broken down by service line (*e.g.* acute care, post-acute care, ambulatory, etc.). These risks were presented to the Executive Compliance Workgroup (“ECW”) in a draft Risk Assessment on June 8, 2018, for review and potential revision and/or additions/deletions.

- 43) The risks described in the draft Risk Assessment are derived from risks identified by the OMIG in its FY2018 Work Plan, and the U.S. Department of Health and Human Services Office of the Inspector General's ("OIG") Work Plans and updates thereto, both of which identify risks that these agencies have determined to be areas of concern for overpayment and/or noncompliance. Other risks outlined in this draft Risk Assessment have been identified internally.
- 44) Following the ECW's review, the draft Risk Assessment will be presented to the Compliance Committees of the System's facilities, units, entities, and programs for their input and identification of additional risks pertinent to their facilities, units, entities, or programs. Any additional risks identified through this process will be included in the draft Risk Assessment.
- 45) The OCC will then finalize the Risk Assessment and identify the impact, vulnerability, and current controls associated with the identified risks, and assign a severity rating to each risk on a scale of 1 – 5, with 5 being the risks having the greatest impact. The OCC will utilize a *Table of Risk Assessment Scoring Parameters*, adopted and derived, in pertinent part, from the Health Care Compliance Association, to prioritize and score the identified risks.
- 46) Once all the risks have been prioritized, the OCC, with the advice of counsel and guidance of the ECW, will establish the FY2019 Work Plan for submission to the System President and Chief Executive Officer for approval and subsequent presentation to the Audit Committee. Through this process, those risks that fall outside the Systems established tolerance for risk, and/or require additional remediation measures not currently available, will be addressed and included in the FY2019 Work Plan. The final risk tolerance determination will be made by the Audit Committee.