NYC HEALTH + HOSPITALS

AUDIT COMMITTEE
MEETING AGENDA

December 13, 2018

12:00 P.M.

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

CALL TO ORDER

- Adoption of Minutes October 15, 2018 — Ms. Emily A. Youssouf

ACTION ITEMS

- Grant Thornton June 30, 2018 Management Letter — Ms. Tami Radinsky

INFORMATION ITEMS

- Compliance Update — Ms. Catherine Patsos

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: October 15, 2018
TIME: 10:30 A.M.

COMMITTEE MEMBERS

Emily Youssouf, Committee Chair
Gordon Campbell
Mark N. Page
Helen Arteaga Landaverde, MPH

STAFF ATTENDEES

Andrea Cohen, Acting General Counsel, Legal Affairs
Matt Siegler, Senior Vice President, Office of the Presiden
John Ulberg, Senior Vice President, Finance
Colicia Hercules, Chief of Staff, Chairman's Office
Lisette Saravia, Senior Executive Secretary, Chairman's Office
Paul Albertson, Vice President, Supply Chain
Yvette Villanueva, Vice President, Human Resources
Jay Weinman, Corporate Comptroller
James Linhart, Deputy Corporate Comptroller
Catherine Patsos, Compliance Officer
Christopher A. Telano, Chief Internal Auditor/Senior Assistant Vice President
Devon Wilson, Senior Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
L. R. Tulluch, Senior Director, Office of Facilities Development
Timi Diyaolu, Controller, Central Office
Edie Coleman, Chief Financial Officer, NYC H+H/Metropolitan
Beverly Addon, Senior Accountant, NYC H+H/Metropolitan
Elsa Cosme, Chief Financial Officer, NYC H+H/Gotham
Kiho Park, Chief Financial Officer, NYC H+H/Coney Island
Ellen Barlis, Chief Financial Officer, NYC H+H/Jacobi/NCB
Michelle Figueroa, Chief Financial Officer, NYC H+H/Harlem
Glenford Hall, Assistant Director, NYC H+H/Kings County
Blanche Greenfeld, Chief Employment Officer, Office of Labor Relations
Roger Zhu, Deputy Chief Financial Officer, NYC H+H/Gouverneur
John L. Cuda, Chief Financial Officer, MetroPlus
Lauren Leveich Castaldo, Deputy Chief Financial Officer, MetroPlus
Jose Santiago, Controller, MetroPlus

OTHER ATTENDEES

Grant Thornton: Tami Radinsky, Lead Engagement Partner; Dana Wilson, Insurance Audit Partner; Lou Feuerstein, Relationship Partner; Steven Dioguardi, Lead Audit Senior Manager.

City Council: Jeanette Merrill

OCTOBER 15, 2018
AUDIT COMMITTEE
MEETING

Call to Order

The meeting was called to order at 11:00 A.M. by Ms. Emily Youssouf, Audit Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee meeting held on June 13, 2018. A motion was made and seconded with all in favor to adopt the minutes.

Fiscal Year 2018 Draft Financial Statements

Ms. Youssouf introduced the information item regarding the Fiscal Year 2018 Draft Financial Statements and Related Notes. Mr. Weinman, Corporate Comptroller, reported on the result of the 2018 financial statement.

- Net position increase $39 Million, compared to last year deficit of $233 Million which is an increase of $272 Million.

Revenue – Increased $467 million

- Net patient service revenue increased by $606 million
  - $404 million DSH Max revenue increase
  - $ 115 million case mix and collectability improvements
  - $67 million increase in managed care risk pool distributions
- Grant revenue decreased by $212 million
  - During 2017, Health + Hospitals recognized two years of VBP-QIP revenue (FY17 and prior year) and 2018 ended without a signed agreement, resulting in no VBP QIP revenue recognition.

Expenses – Increased $252 million

- Personal services increased $317 million
  - $356 million increase for collectively bargained structured payments to be paid through 2022
  - $69 million reduction due to head count control efforts
- Overall, current ratio which is a measured of liquidity is sitting at 1.02 anything above 1 is relatively good. It means that we have more current assets than current liabilities, an increase over last of year .91.
- Days cash-on-hand, we had a $738 Million cash balance at the end of year with 36 days in cash.
- Net days revenues is at 65 is an increase which is due to the increase in revenues and is about at state-wide average.

Grant Thornton has completed its audit of the Corporation's 2018 financial statement and will be issuing an unmodified opinion. An unmodified opinion states that the financial statements are presented fairly, in all material respects.

Health + Hospitals adopted a new accounting standard, GASB 83, for recognizing liabilities for asset retirement obligations. This standard applies to assets that require a legally enforceable disposal method. After review of the standard, Health + Hospitals has determined that the obligation is immaterial to the overall financial statements and has met the requirements of disclosure outlined in the standard.

Ms. Arteaga Landaverde asked what the goal is for the 30 day cash on hand.

Mr. Ulberg answered that the City-Wide average is our goal, but it will take us a little while to get there. We are working with the State to bring more consistency to the funds such as Medicaid and DSH. We are targeting a two six-month payment plan a year.

Grant Thornton Audit Report

Tami Radinsky, Lead Engagement Partner introduced herself and the team introduced themselves as follows: Dana Wilson, Insurance Audit Partner; Lou Feuerstein, Relationship Partner; Steven Dioguardi, Lead Audit Senior Manager.

Ms. Radinsky presented by outlining the audit process and its various stakeholders.

Our Responsibilities

- Performing an audit under US GAAS and *Government Auditing Standards* of the financial statements prepared by management, with your oversight
- Forming and expressing an opinion about whether the financial statements are presented fairly, in all material respects in conformity with US GAAP
- Forming and expressing an opinion about whether certain supplementary information is fairly stated in relation to the financial statements as a whole
- Communicating specific matters to you on a timely basis; we do not design our audit for this purpose.

Management

- Preparing and fairly presenting the financial statements in conformity 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

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 the company'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 related oversight responsibilities
- Your views regarding our current communications and your actions regarding previous communications

Audit Process

As part of the audit for 2018, there are various deliverables that we will be issuing. Later in the year, Mr. Wilson will be issuing a December 31st statutory audit on the Health Plans. To-date we have substantially completed the audit procedures as follows:

- New York City Health and Hospitals Corporation fiscal year ended June 30, 2018
- NYC Health + Hospitals Accountable Care Organization Inc. annual financial statements for the fiscal year ended June 30, 2018
- Metro Plus Health Plan's annual financial statements under GAAP for the fiscal year ended June 30, 2018
- Metro Plus Health Plan's annual statutory financial statements for the fiscal year ending December 31, 2018
- NYC Health + Hospitals Insurance Company's annual statutory financial statements for the fiscal year ending December 31, 2018

The cost reports for certifications will be issued as soon as the instructions are released from the appropriate entities.

Summary of the Audit Process - the stages of the various audit we go through all the way from planning through conclusion. We will not go through them unless there are specific questions, but it is important to point it out.

Fraud Considerations and Risk of Management Override

As auditors, we are responsible for planning and performing the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether caused by error or by fraud. We consider, among other things:

- Code of conduct policy/ethics
- Effective and independent oversight by those charged with Governance
- Process for dealing with whistle-blower allegations
- Internal audit/corporate compliance activities
- Entity's risk assessment processes

Internal Control Matters

We are not here to discuss internal control matters consistent with past practices from your formal auditing. We will come back in a couple of weeks with our formal management letter which discusses the control deficiencies we identified as part of the audit process. Control deficiencies are defined in three levels: control deficiency all the way to the most severe material weakness. We are happy to report that they are no material weaknesses.

Mr. Dioguardi stated that first area I would like to address is the accounts receivable from patients, net patient service revenues. This is one of the most significant line items on the financial statements of the organization. It is also an area that has a significant component that is a management estimate. Anytime there is a management estimate, it requires additional high sensitivity from an audit perspective through viewing the assumptions that goes into these estimates and also additional testing to ensure that those assumptions are reasonable in coming up with ending balances. As part of the audit procedures, we review management's calculations, their assumptions and do a substantial amount of testing over those assumptions, ultimately coming to the conclusion that we are in agreement with management assumptions, their methodology for determining their receivables, net patient service and revenue balances. In addition, as part of our detail testing of the assumptions and the information going into it, we reviewed detailed transactions at the patient level. We selected a pretty sizable sample of patient records, we reviewed the

patients' records from initiation (in-take) all the way through billing and ultimately collection. As result of the testing, we agree with management's assumptions and there are no significant exemptions or material findings related to the accounts receivables and the underlining testing.

As it relates to estimated amounts to and from third-party payors. This is another area that relies heavily on management's estimates. As part of our procedures, we obtained management's calculations and, their underline assumptions that we use for the calculations. In this area, in particular, we bring in specialists who specialized in this area of third-party payer settlements to deal heavily with Medicaid, Medicare issues and various hosts of third-party payors issues. We brought them to take a deep detail look at management's assumption calculations and again we agree with management's estimates and had no significant exemptions or material findings.

Ms. Radinsky stated that since Heath + Hospitals implemented a new system for accounts payable, it was identified as a high risk area. The previous audit team identified that there was an issue, but they could not quantify what it was because of the old system being used. Our team spend a lot time in the area of accounts payable, looking at cash receipts and comparing them to the general ledger at year end and other unreportable liability testing. We came up with a projected misstatement, which means we identified true errors and projected it to the total population of accounts payable. The accounts payable year end is about $450 Million. That is the population we talk about that relates to vendor and account payable. That is the area that we isolated and had the issues involved. In discussing it with management, since this is a non-cash item, it was decided that it was not prudent to book the full adjustment this year and it will flush out next because of the new system.

Mr. Feuerstein commented that management took a conservative position, the $50 Million that we projected would have reduced the liability balance rather than take the benefit this time, we left it in the financial statement still accrued for and eventually will flush through the system in 2019.

Ms. Radinsky said that just to conclude, to bring it back to the level of control deficiency, we felt that this was significant enough to report it to the committee but not significant enough to make it a material weakness, so we call this a significant deficiency which will be reported in the financial statements.

Mr. Wilson reported on MetroPlus and stated that there are three primary areas of significant risk:

Claims Payables Reserve (IBNR) –
A higher estimation uncertainty, a critical area that we focus large amount of efforts on both at Health + Hospitals and our health insurers nationally. In this specific case we outsourced to an actuarial firm. The first thing we do with the actuarial firm is review their credentials as well as the assumptions they are making and found them satisfactory for Health + Hospitals processes and ours as well. When they issue an actuary evaluation, they issue an opinion that states that the numbers they projected and determined are fair and accurate if the data they received from management is complete and accurate. As the auditor, we have to close that gap in order to use their work so we issue a disclaimer.

The process we go through first is making sure that the data they received is complete and we do that by tying it to different sources within the organization both from the cash side and the process side and in large part to the general ledger. Once we determined that is complete, we have a homogeneous and full population, we then select a sample

of that population and test those items at a 92% confidence level which is a sample of 30 in this case to make sure we have accuracy. In this case we found no exemption both on the completeness and accuracy testing determined again that assumption used and methodology used were fair.

In addition, we do a retrospective review by looking at the prior year reserve of June 30, 2017 to see how that flushed out and we also have a couple of months' worth of data to see how the June 30, 2018 reserve is flushing out and concluded that the IBNR section is fairly stated.

Risk Transfer Adjustment

It has a very similar process as it relates to completeness and accuracy. Considered the experience, objectivity and capability/competence of the external actuarial specialist, Wakely. Tested the inputs related to the Risk Transfer calculations along with getting support from third party actuaries and industry data. Tested, with internal actuary, the methodologies and assumptions used by Wakely in the calculation for reasonableness. Completed a look back analysis to compare the prior year estimates to what was settled in 2018 related to the prior year reserves. We concluded that the amount Wakely determined is a fair amount.

Revenue Premium Recognition

High risk area, mainly because of its susceptible to fraud. We have tested numerous new transactions throughout the year and have concluded that they are fairly stated as well.

In conclusion, Mr. Wilson stated that since we are first year auditors, we are auditing both June 30, 2017 & June 30, 2018, we will come back to audit us on December 31st. We have an 18-month period that we are auditing. We have broken the audit into 3 6-month periods to be as efficient and effective as possible. We will come back now and work with the MetroPlus team to wrap up the 12/31 audit.

Mr. Wilson answered that the data sent to the actuary, they are using both local and national assumptions to project liability. If that data is not accurate, the methods and assumption that applied to it are also going to be inaccurate so we have to test that and we found that the data is 100% accurate. The risk is that we are working with estimates.

Ms. Radinsky addressed a couple of key required communications, as Mr. Weinman mentioned earlier that they be issuing an unmodified opinion. The financial statements for 2017 will be audited by another firm which is a requirement anytime you take over a first year audit.

As mentioned earlier, during FY 2018 Health + Hospitals adopted an additional GASB Statement 83. We did test on the schedules that management put together, it is immaterial to the financial statement as whole.

The next communication emphasizes the unrecorded difference between the general ledger and the supported detail the $50 million in account payables that will also be part of the management representation letter which Finance will sign prior to us issuing the financial statement.

We had no disagreement with management, which got us to where we are today.

Ms. Youssouf asked if there were questions and asked for motion to accept the financial statements and it was seconded.

Internal Audits Update

Mr. Telano reported external audits going on by outside regulatory agencies. The first one is Controls over Equipment by the State Comptroller's Office. That audit is complete and we received the draft report September 27th, the responses are due on October 27th. From my perspective, we have $3.5 billion in office and medical equipment and they found discrepancies of book value that total of $17,924, the accounts revealed a 5% error rate. They also found record keeping items within the fixed asset system. There is a comment on the first page of the report concerning the lack of their ability to track 600 infusion pumps worth $1.7 million, that statement is incorrect. I have been trying to work with them to have it remove it. We will see, we may have to state in the response that that statement is incorrect.

Moving on to the audit with the IRS that is set to begin on October 30th. The goal is verify the tax-exempt status of Health + Hospitals as a non-profit organization. I will keep the committee abreast of the status, they are planning on being here only 3 days and hope they are satisfied with what we have.

Some of the other audit activities that Internal Audits has been doing is that we have been given the responsibility of being the liaison between the Inspector General and any reports they issue of Health + Hospitals. There were six outstanding reports since 2017 and they all have been addressed and finalized.
Mr. Telano stated that the same thing goes with anonymous letters received by the Chairman's office or the President. That is also the new process in which they are being sent to Internal Audit for an independent investigation. There have been two passed on to us and one we have resolved and issued a report on. Lastly, duties related to Auxiliaries audits, as of this date 15 of the 22 have been issued.

CORPORATE COMPLIANCE UPDATE

Ms. Patsos began her update with Monitoring Excluded Providers – As required by the Federal and state regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General ("OMIG")1 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.

During the period June 1, 2018 through September 30, 2018, there was one excluded individual, one excluded vendor, two disciplined providers and one disciplined vendor.

The excluded individual is a human resources administrator at NYC Health + Hospitals/Kings ("Kings") who was engaged by NYC Health + Hospitals through a staffing agency. The OCC was informed about the excluded individual on July 31, 2018. She worked at Kings from April 2018 through the end of July 2018. The OCC is investigating the possibility of an overpayment for this individual and will be discussing this issue with the agency that coordinates the hiring of agency staff for the hospitals.

On June 13, 2018, the OCC was informed about an excluded vendor, Unipro International, which furnished uniforms for NYC Health + Hospitals. The System did not utilize this vendor after the effective date of the exclusion. The OCC worked with the Office of Supply Chain to ensure that NYC Health + Hospitals will not transact any further business with the vendor, or solicit new business from this vendor.
Ms. Arteaga Landaverde asked why they were excluded.

Ms. Patsos responded that they either come up on the Federal or State exclusion list for having problems with Medicaid/Medicare issues.

Ms. Youssouf asked even for a uniform provider? To which Ms. Patsos responded that if the vendor has committed fraud with the resources they get from Medicaid/Medicare, they will be excluded.

Ms. Arteaga Landaverde asked for how long are they on the list?

Ms. Patsos answered depending on the severity, it could be 5 or 10 years.

The next one is about a disciplined PAGNY physician working at NYC Health + Hospitals/Harlem, who had restrictions placed on his license requiring that his services be supervised by a board certified physician. The OCC confirmed that Dr. Wright, Chief Medical Officer at Harlem, and Dr. Allen were aware of the restrictions on the physician's license, and that he is being adequately supervised.

There was also a community physician that had restrictions placed on his license as well, which require that the physician only practice medicine while being monitored by a licensed physician board certified in an appropriate field. The community physician is also precluded from ordering, prescribing, distributing or administering controlled substances. The OCC confirmed that this physician is not credentialed at any of the facilities to which he has referred patients, and therefore is unable to practice medicine in any such facilities. This is a disciplinary action that would lead to some restrictions placed on his license.

Finally, a disciplined vendor, Mick Radio-Nuclear Instruments, from which the System purchased clinical supplies related to brachytherapy, was a match for a World Bank sanction. NYC Health + Hospitals has terminated its relationship with this vendor.

The OCC periodically screens the DMF and NPPES files as part of its sanction screening process. No providers were identified on the DMF or NPPES during the period June 1, 2018 through September 30, 2018.

Privacy Incidents and Related Reports During the period of June 1, 2018 through September 30, 2018, forty-two (42) privacy complaints were entered into the RADAR Incident Tracking System. Of the forty-two (42) complaints, sixteen (16) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures ("OPs"); five (5) were determined to be unsubstantiated; nineteen (19) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security OPs; six (6) are still under investigation; and one (1) is on hold due to a law enforcement delay request from the United States Attorney General for the Eastern District of New York. Of the sixteen incidents confirmed as violations, nine (9) were determined to be breaches.

Of the nine (9) incidents that were determined to be breaches, three (3) of them were caused by one of our vendors, CIOX, which responds to medical records requests on the System's behalf. In total, CIOX has been responsible for ten (10) HIPAA breaches this year. Consequently, the Chief Corporate Compliance Officer CIOX is doing to avoid further breaches. She informed the CCO that CIOX has been and/or will implement the following corrective actions:

- Perform a 100% quality assurance check on records requested from Bellevue and Jacobi, from which the majority of the breaches came, to ensure that the correct documents are being sent to the correct requester;

- Conduct unannounced on-site audits of their workforce at Bellevue and Jacobi to determine whether they are following proper policies and procedures, and HIPAA requirements; and
- Develop an action plan based on the results of the audits to bring their workforce into compliance.

In addition, the Office of Supply Chain has engaged a consulting group to review CIOX's services and determine whether there are opportunities for improvement or change. Currently, the facility Health Information Management ("HIM") Directors oversee CIOX's services; however, we are in the process of centralizing this function. In the meantime, the Office of Supply Chain has identified a temporary point person to act as a liaison between CIOX and the HIM Directors until this function transitions to finance.
Ms. Youssouf commented that the Office of Supply Chain is looking into replacing them.

Mr. Albertson stated that they are reviewing their agreement that went into place a few years ago and we are trying to work on a solution. They are a lot vendors out there with this type of work.

Ms. Youssouf asked how long is the contract is. To which Mr. Albertson replied that it is through next summer.

Ms. Youssouf asked to keep the committee informed as to the status.

Ms. Patsos continued and reported on the other incidents:

This Incident occurred when a temporary clerk in the outpatient Behavioral Health Clinic at Bellevue inappropriately disclosed the location/type of clinic where the patient was receiving services to the patient's employer while attempting to verify employee financial information.

This incident occurred when a temporary agency nurse from Perfect Choice Staffing discussed a patient's sensitive health information in an area where other individuals were able to overhear her.
Both of these individuals have been released of their duties. As part of the mitigation, a procedure has been established whereby human resources and the agency from which the employee came are notified of the breach, and human resources flags such individual as not being employable by the System in the future.

Ms. Youssouf asked if Human Resources is aware of these are the first incidents with these vendors?

Ms. Villanueva answered that we have had other incidents throughout the years, not necessarily related to this incident, and have communicated to our vendor Vizient not to use within the system. We need to tighten that protocol, have it in writing and communicate it widely to the HR Directors because, I think that is a gap for us.

Ms. Youssouf said that sounds like it is and to let us know when that is in place.

Ms. Patsos continued with the incidents:

This incident occurred when the program type where a patient was receiving services was disclosed by a NYC Health + Hospitals social worker to an external home care agency, with which the System does not have an existing relationship or a business associate agreement. Based on an investigation of the incident, it was determined that,

although the disclosed PHI was limited in nature, it included enough sensitive health information of the patient to reasonably infer that a behavioral health condition, diagnosis or treatment was involved.

This incident occurred when a business associate of NYC Health + Hospitals mistakenly sent the wrong patient records to an outside law firm. Based on an investigation of the incident, it was determined that the disclosed PHI included the patient's name, date of birth, medical history and treatment, and diagnostic information.

This incident occurred when a business associate of NYC Health + Hospitals mistakenly sent the wrong patient records to a records retrieval company. After an investigation into the incident it was determined that the disclosed PHI included the patient's name, birthdate, diagnosis and social security number.

This incident occurred when a physician disclosed a patient's diagnosis information in the presence of the patient's mother. The patient reported the incident of unauthorized disclosure himself. Nonetheless, notification was sent to the affected individual on September 12, 2018.

This incident occurred when a member of the patient relations department inadvertently sent two letters, each intended for a deceased patient's family, to the address of the other patient. Both letters were recalled and notifications were sent to the affected individuals' next of kin.

This incident occurred when a patient removed a sign-in sheet from the registration area at Jacobi. Based on an investigation, it was determined that the PHI on the form was limited to patients' names, appointment times, and whether it was their first visit to the clinic. In response to this incident, steps have been taken to better secure the registration areas at Jacobi.

Ms. Youssouf asked what is the procedure for the other facilities.

Ms. Patsos answered that she was not sure.

Ms. Youssouf that that is something that needs to be looked at?

Mr. Campbell stated that perhaps Mr. Matthew Siegler can ascertain if this is unique or common place, if so, we need to build a protocol and report to the Committee at the next meeting.

Ms. Patsos stated that the final incident once again involves CIOX. The incident occurred when a business associate of NYC Health + Hospitals mistakenly sent a patient's records to another patient's mother. The PHI disclosed included information such as the patient's address, medications, and medical procedures that the patient had undergone at Lincoln.

Office for Civil Rights ("OCR") Inquiries Regarding Privacy Incidents

There was one follow-up inquiry by the OCR since May 31, 2018. The inquiry pertained to the stolen laptop incident at NYC Health + Hospitals/Harlem, which the OCC previously reported to the Audit Committee. The OCR's follow-up inquiry requests additional information and documents pertaining to the breach including more details about laptops and biomedical devices at Harlem.

Update on Policy for Securing Biomedical Devices

As reported at the June 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 Services ("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 next step in this process is to identify an enterprise-wide Biomedical Counsel that will be accountable for biomedical devices across the System, and present the issue and need for such a policy and procedure. Thereafter, the OCC and EITS will work with such Counsel to identify the scope of the issue and requirements of such a policy and procedure, upon which a policy and procedure can be based. In addition, EITS is working on revising a 2010 Device and Media Control Plan, which addresses the receipt, movement, and removal of devices and electronic media that contain electronic health information into, within, and out of NYC Health + Hospitals.

Compliance Reports

For the period June 1, 2018 through September 30, 2018, there were one hundred and forty-four (144) compliance reports, three (3) (2.1%) of which were classified as Priority "A";7 fifty-one (51) (35.4%) were classified as Priority "B"; and ninety (90) (62.5%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints.

Two of the Priority "A" reports were filed by the same reporter, asserting the same complaint. The reporter was an involuntarily admitted inpatient in the behavioral health service at NYC Health + Hospitals/Coney ("Coney"), who alleged that he was sexually assaulted by Coney staff. The allegations were investigated by Coney's behavioral health leadership and found to be unsubstantiated. Because of the nature of the complaint, however, the behavioral health leadership at Coney reported the allegations to the New York State Justice Center, which investigates allegations of abuse and neglect. The New York State Justice Center acknowledged receipt of the complaint; however, that investigation is still pending.

In the third Priority "A" report, out of NYC Health + Hospitals/Elmhurst ("Elmhurst"), the reporter alleged ongoing harassment, and that she "fears for her life" while in the workplace. Due to the nature of the allegations, the OCC worked with Human Resources at Elmhurst to advise on potential resolutions. Ultimately, this complaint was referred to Human Resources and Hospital Police at Elmhurst as a potential violence in the workplace complaint. Ultimately, it was determined that, although the reporter's allegations related to potential workplace violence were unsubstantiated, the reporter should be transferred to NYC Health + Hospitals/Queens. It should be noted that the reporter's issues were deemed to be essentially a domestic dispute, and no violence actually occurred on NYC Health + Hospitals premises. In addition, on October 15, 2018, the OCC was informed that Hospital Police at Elmhurst determined that the allegation of selling drugs at the facility was unsubstantiated.

Update on OneCity Health

As part of the Attestation, OneCity Health Partners were asked to confirm that they have completed the compliance training requirements, and to specify the method by which such training was conducted. In addition, they were asked to submit proof of OMIG compliance program-related certifications and certifications of compliance with the Deficit Reduction Act of 2005, if they are required by law and/or OMIG policy to obtain such certifications. Partners were

also asked a series of questions to confirm whether or not they have met the requirements outlined in NYC Health + Hospitals' Principles of Professional Conduct ("POPC").

Of the one hundred sixty-eight (168) OneCity Health Partners who executed a Schedule B for Phase III, one hundred sixty (160) Partners completed and submitted the Attestation to OneCity Health. Seven (7) Partners did not submit the Attestation, and one withdrew from Phase III. The seven (7) Partners that failed to submit the Attestation have been sent letters terminating their Phase III Schedule B Agreement.

As reported at the June 2018 Audit Committee meeting, OneCity Health engaged a third-party auditor, Bonadio & Co., LLP ("Bonadio"), to audit OneCity Health's internal processes, including Partner selection and contracting, quarterly reporting, funds flow, and the Partner portal. Bonadio has completed its audit of OneCity Health, and submitted its final audit report to the Board of Directors of OneCity Health on October 9, 2018.

As reported at the June 2018 Audit Committee meeting, on October 5, 2017, HHC ACO, Inc. ("HHC ACO") submitted an application to the New York State Department of Health ("DOH") seeking approval for an "all payer" ACO, which includes Medicaid, commercial insurance, and Medicare Advantage patients. That application is still pending.

The Centers for Medicare and Medicaid Services ("CMS") issued a proposed rule for CY2019 of the Medicare Shared Savings Program ("MSSP"), which sets forth a number of proposed changes to the MSSP, including changes that encourage ACOs to take on greater risk. The final rule is expected to be released later this year. Based on the provisions of the final rule the HHC ACO will determine whether to adopt a one-sided or two-side risk model in CY2019. The HHC ACO earned shared savings of $2,182,360 in CY2017, and scored better than ninety percent (90%) of all other ACOs on preventative health measures.

Deficit Reduction Act of 2005 ("DRA")

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

- Established and disseminated to all their workforce members and business partners, including management and contractors or agents, written policies that provide detailed information about:
  - 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 and to comply with that, the OCC issued on 9/26/18 a notice and attached memorandum to workforce members (if one exists):
  - Information about the Federal False Claims Act and comparable New York State laws;
  - A specific discussion of the rights of the 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.

Aetna Desk Review

As reported at the June 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.

On April 30, 2018, the OCC received Aetna's Compliance Program Elements Audit Report (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 corrective action plans to Aetna for the failed compliance requirements, which the OCC did on May 25, 2018.

On August 27, 2018, the OCC submitted NYC Health + Hospitals' report on the implement of its corrective actions plans, most of which involved changes to Operating Procedures. On September 18, 2018, the OCC received an email from Aetna requesting additional information in response to one of the System's corrective action plans, which the OCC provided on September 20, 2018. The OCC is awaiting Aetna's final response to the corrective action plans.

The Risk Assessment Process

The risks described in the draft Risk Assessment were derived from the OMIG's Work Plans, and the U.S. Department of Health and Human Services Office of 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 the draft Risk Assessment were identified internally.

Ms. Youssouf requested that that table of risk be presented or sent to the Committee.

Ms. Patsos stated that once all the risks were prioritized, the OCC developed a draft FY2019 Work Plan, which included the risks from the Risk Assessment with the highest risk prioritization scores in each service line. On September 10, 2018, the ECW met to review and discuss the draft FY2019 Work Plan. As a result, the ECW identified certain issues in the draft FY2019 Work Plan for which follow-up was necessary. Once the follow-up is completed, the ECW will meet again to finalize the FY2019 Corporate Work Plan for submission to the System President and Chief Executive Officer and the Audit Committee for approval. Through this process, those risks that fall outside the System's established tolerance for risk, and/or require additional remediation measures not currently available, are included in the FY2019 Corporate Work Plan. The final risk tolerance determination will be made by the Audit Committee.

Records Management

In May 2018, a Records Task Force was formed to address the issue of more than 621,000 boxes of paper-based files in off-site storage at Iron Mountain, at a monthly storage rate of more than $335,340, and annual storage rate of more than $4,024,080. We have identified in total, approximately 138,700 boxes that can be slated for destruction, which would save the System approximately $74,898 monthly, and approximately $898,776 annually.

After a series of meetings with Iron Mountain, the RMO, in conjunction with the Office of Supply Chain, was able to put in place the following immediate steps to curb the mounting storage at Iron Mountain

- No boxes will be sent to Iron Mountain unless a thorough analysis is completed, including whether records that need to be retained are available in legally acceptable digital format.
- In the event that boxes must be sent to storage, pick up restrictions will be implemented (*i.e.* no pick up without detailed box indexing including department name, unit name, types of records, detailed description, and most importantly destruction date).
- Restrict individual facility records management activities, including sending boxes off-site, to one or two Facility Records Officers per site, who will work with the RMO. Note that a total of over 600 NYC Health + Hospitals workforce members have been interacting with Iron Mountain regularly, often sending boxes off-site with no labelling and no retention dates.
- With the help of the Facility Records Officers, begin identifying records at Iron Mountain that have no retention requirements and/or are past their retention period.

Workforce Member Compliance and HIPAA Training

Over the last year, the OCC has made significant revisions and updates to how the System provides Compliance and HIPAA training and education to its workforce members and business partners. The revisions and updates were designed to enhance and ease the training and education process, while simultaneously meeting regulatory requirements in a more efficient and expeditious manner. The following is a brief summary of the OCC's efforts to enhance the training and education process:

- Combined previously separate annual courses (*i.e.* Compliance and HIPAA) into one (1) course entitled "*Workforce Member General Compliance/HIPAA Training and Education*" – making it easier for workforce members to meet regulatory requirements in one step;
- Developed a similar yet separate course for new workforce members, thus allowing a clear distinction of completed required orientation training, which is now maintained in their records;
- Developed "tracks" in both online courses which are more specific to the workforce member's role at NYC Health + Hospitals (*e.g.* physician track, non-clinical workforce member track, and volunteer/student track); Replaced previous in-person/live training with ELM training, which has allowed Compliance Officers to dedicate more time to other critical compliance activities;
- Worked with Human Resources Shared Services ("HRSS"), Workforce Development, and Affiliate Administration across the System to ensure that the training and education is available to a broader population of the workforce than in the past;
- Worked with EITS leadership to revise the process for new workforce member training, which ensures that the System meets its regulatory requirements, as well preventing inappropriate access to clinical systems that contain sensitive patient information prior to receiving HIPAA training; and
- Worked with HRSS to offer, for the first time, in June and July 2018, a method of online training for the incoming class of resident physicians across the System. More than 1,800 residents were able to complete their training and education obligations prior to their start date, which lead to a faster and more seamless assignment of their clinical duties. This lead to a completion rate within the first week of on-boarding of close to 97%.

Board of Directors Compliance Training In accordance with New York State Social Services Law and regulation, and consistent with NYC Health + Hospitals' OP 50-1, Corporate Compliance and Ethics Program, as part of the Systems' compliance program, governing body members are required to receive compliance training. Accordingly, the OCC will be scheduling such training for the System's Board of Directors for early next month.

Ms. Youssouf asked for a motion to hold an Executive Session to discuss potential legal implications, motion was made and seconded. There being no other business, the meeting was adjourned at 12:20 P.M.

December 5, 2018

Management and Board of Directors
New York Health and Hospitals Corporation
New York, New York

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Ladies and Gentlemen:

In connection with our audit of New York Health and Hospitals Corporation's ("NYC Health + Hospitals" or the "System") financial statements as of June 30, 2018 and for the year then ended, auditing standards generally accepted in the United States of America ("US GAAS") require that we advise management and the Board of Directors (hereinafter referred to as "those charged with governance") of the following internal control matters identified during our audit.

Our responsibilities

Our responsibility, as prescribed by US GAAS, is to plan and perform our audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to fraud or error. An audit includes consideration of internal control over financial reporting (hereinafter referred to as "internal control") as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, we express no such opinion on internal control effectiveness.

Identified deficiencies in internal control

We identified the following internal control matters that are of sufficient importance to merit your attention.

Significant deficiencies

Our consideration of internal control was not designed to identify all deficiencies in internal control that, individually or in combination, might be material weaknesses or significant deficiencies; therefore, material weaknesses or significant deficiencies may exist that were not identified.

A deficiency in internal control ("control deficiency") exists when the design or operation of a control does not allow management or employees, in the normal course of performing their

assigned functions, to prevent or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the System's financial statements will not be prevented or detected and corrected, on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

We consider the following identified control deficiency to be a significant deficiency.

Accounts Payable

Observation

During fiscal year 2018, NYC Health + Hospitals transitioned to PeopleSoft ERP for the general ledger function, including Vendor Accounts Payable. We noted that while the new PeopleSoft accounts payable system maintains adequate reports and reconciles to the general ledger, the previous 30-year old system, did not.

Recommendation

We recommend that management maintains controls at an appropriate level of precision to prevent misstatement of the accounts payable balance and continues to work to find ways to reconcile balances for the old system for the remaining time it is in use. Any unusual reconciling items should be investigated and addressed in a timely manner.

Management's Response

In fiscal year 2018, NYC Health + Hospitals implemented a new accounting system that, in part, contains the transactions related to accounts payable. This new system, PeopleSoft ERP, has allowed NYC Health + Hospitals to more accurately track and reconcile accounts payable which has increased the precision of the amounts reported on the financial statements while it transitions away from using the old system. Additionally, the new system provides NYC Health + Hospitals reports generated to perform detailed analysis on a multitude of financial reporting areas. Also, controls were built into the system that increase oversight and approvals to help mitigate discrepancies in transactional reporting that were present with the old system.

While the old system is not expected to contribute to the accounts payable balance at the end of fiscal year 2019, it is worth noting that the transactions remaining in the system are immaterial to the financial statement balances reported for accounts payable.

Control deficiencies

A deficiency in internal control ("control deficiency") exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis.

We identified the following control deficiencies:

Patient Accounts Receivable and Net Patient Service Revenue - Credit balances in patient accounts receivable

Observation

During our audit of Patient Accounts Receivable as of June 30, 2018, we noted that credit balances relating to patient accounts receivable totalled approximately $80 million, similar to that reported in prior years' audits. Through audit procedures performed, we determined that the portion of the credit balances that represented liabilities due to patients and payors was immaterial. The credit balances primarily appear to be a result of billing adjustments. However, we noted that management does not have a formal policy in place to accumulate and analyze the credit balances at the patient level in order to determine the proper accounting treatment for the credit balances.

Recommendation

We recommend that management develops a process to analyze the nature of the credit balances within patient accounts receivable and, on a monthly basis, record adjustments in the accounting records to reflect their proper disposition. In addition, management should investigate and determine the root cause for the credit balances in order to develop solutions to address systematic issues that result in credit balances within accounts receivable.

Management's Response

Through the implementation of our new billing system, EPIC, credit balances are electronically queued and routed to employee workflows for follow up. This process will greatly increase our ability to track and correct incorrect postings and reduce overall credit balances. Additionally, NYC Health + Hospitals is enrolling more payors into electronic remittances so that payments are properly recorded to the correct patient account, thus reducing credit balances.

Patient Accounts Receivable and Net Patient Service Revenue - Patient revenue recorded after fiscal year-end for services provided prior to fiscal year–end

Observation

We noted that patient service revenue is recognized for services based on the date those services are entered into the patient accounting system rather than as of the date the service was provided. As a result, the recording of revenue can occur up to several days subsequent to the date the service was provided. We noted that in fiscal 2017, revenue was recorded in a similar manner. Through audit procedures performed, we determined that the net impact of the improper cutoff of revenue between fiscal year 2017 to fiscal year 2018 was immaterial. However, we noted that management does not have a procedure in place to determine the magnitude of the current year revenue captured in the subsequent year and assess the net impact of the improper revenue cutoff.

Recommendation

We recommend that management develops a process to determine the amount of revenue recorded in the month subsequent to the month that the service was provided and assess the net impact in order to determine if an adjustment to revenue is necessary.

Management's Response

Management developed a report to measure the impact of subsequent postings on the reported accounts receivable and revenue. The report will be used during fiscal year 2019 to ensure that the financial statements are reasonably stated.

Patient Accounts Receivable and Net Patient Service Revenue – Controls over manual data entry into the patient accounting system

Observation

As part of our testing of patient service revenue and the accounts receivable sub-ledger, we noted two high dollar manual adjustments to patient account balances that were made in error and not identified and corrected as part of NYC Health + Hospitals' existing controls and procedures. Upon further review we determined that NYC Health + Hospitals does not have a consistent policy in place across all facilities to periodically review high dollar manual adjustments to patient account balances and high dollar patient account balances.

Recommendation

We recommended that NYC Health + Hospitals develop and formalize a policy consistent across all facilities, which requires periodic review of high dollar manual adjustments to patient account balances and high dollar patient account balances to ensure the accuracy of patient service revenue and accounts receivable.

Management's Response

NYC Health + Hospitals is building reports in Unity and Soarian to identify accounts with high dollar charges which will allow the facilities' Directors of Revenue Management to identify abnormal charges. Additionally, the transition to EPIC and the related charge review workflow implementation makes the identification and ownership of these accounts much easier. We are building reports that are expected to be available by the end of the third quarter of fiscal year 2019.

Information Technology – Unidentifiable Users

Observation

By reviewing the active account listing, we identified one person having a Network administrator account that was not listed as an employee or outside consultant.

Recommendation

We recommend that management reviews the active account listing to ensure that only appropriate and active users have access as a Network administrator. In addition, we recommend that management considers removing administrator responsibilities from personnel who are not part of the IT security group. If segregating security administration responsibilities is not feasible, personnel independent of the functional department should perform a periodic review of administrative users' activities to ensure that only authorized activities are performed. Evidence of this review should be retained.

Management's Response

NYC Health + Hospitals has verified that the identified person is a consultant and will update the active account listing to reflect that information. Additionally, the IT department already implemented a process which requires all staff seeking domain access to go through PeopleSoft's IdentityIQ which generates an active directory account. Any staff seeking administrative permissions go through a separate request through ServiceNow which creates an end user account. Finally, IT is currently developing a ServiceNow catalogue item to track the request for domain administrator access which will be reviewed and approved the by Active Directory Domain administrators, the only group allowed domain access. Currently, review of access is not performed by personnel independent of the Active Directory Domain administrators group. However, IT will work to implement an independent review process during fiscal year 2019.

Information Technology - Segregation of Duties

Program Maintenance

Observation

We noted that five PeopleSoft security administrators have access to source code. Additionally, we noted that seven PeopleSoft security administrators have access to modify production.

Recommendation

We recommend limiting program maintenance access to IT personnel who do not have security administrator privileges. If segregation of duties is not feasible, management should consider implementing mitigating controls (e.g., an activity log report of the administrators' actions reviewed by an independent party on a regular basis) to compensate for the lack of segregation around operating and security related functions.

Management's Response

For the PeopleSoft application, security and system administration are managed by the same team. However, as recommended by Grant Thornton, NYC Health + Hospitals already has a process in place where all the migrations are done using a version control and migration tool called PHIRE. This tool maintains all the activity logs and every migration has an audit trail of who had performed a migration and what objects were migrated. NYC Health + Hospitals will implement audits of these pre-existing logs going forward.

Information Technology - Shared Account

Observation

We noted that 'sysadmin' account on the PeopleSoft database is shared by the PeopleSoft Administrators team and the Database Administrators team.

Recommendation

We recommend that in order to promote accountability for activities performed using privileged accounts, management requires unique user IDs be utilized so that system activities are traceable to an individual.

Management's Response

Management agrees with the recommendation and, moving forward, will request that all individuals associated with Database Administrator and/or PeopleSoft Administrator teams maintain individual accounts. These unique accounts associated with each individual "team member" will permit system-traceable activity, as recommended. We will implement this process prior to the end of calendar year 2018.

Information Technology - User Access Review

Observation

We noted that the System does not perform a formal periodic review of Network PeopleSoft, Unity, and Soarian user entitlements to ensure access changes were conducted in accordance with management's expectations.

Recommendation

We recommend management performs a comprehensive review of user access entitlements on a regular basis (i.e., at least once per fiscal year). The review should be performed by department heads and/or business owners independent of security administration functions, based on system reports provided by system administrators and include the following:

- Review Network, PeopleSoft, Unity, and Soarian account listings to ensure generic/group IDs are appropriate (use of such is strongly discouraged and should be minimized to the extent possible)
- Review Network, PeopleSoft, Unity, and Soarian account listings to ensure accounts for terminated employees have been disabled or removed
- Review individual user access to ensure access is restricted to appropriate functions based on current job responsibilities
- Review access to powerful privileges, system resources and administrative access to ensure access is restricted to a very limited number of authorized personnel

The access review should be formally documented by the department head and evidence retained. Any identified conflicts in access rights should be followed up and resolved in a timely manner.

Management's Response

NYC Health + Hospitals is in the process of implementing the compliance module of SailPoint IdentityIQ. The first re-certification processes to be configured are EPIC users, non-employee, PeopleSoft HR roles, and PeopleSoft ERP roles. All re-certifications will be performed on a quarterly basis and will be functional during fiscal year 2019 (this will not cover Unity or Soarian at this time). The result of the re-certification process will be to either revoke or extend access to the network/application.

All privileged accounts (administrative access) are tied to the end user account within SailPoint IdentityIQ. When a user is terminated, their privileged account is also terminated.

Information Technology - User Administration: New Hires

Observation

Although a ticketing system is in place, management was unable to provide adequate documentation for the new hire sample we selected for testing due to the switch from Remedy to ServiceNow.

Recommendation

We recommend that IT maintain complete documentation regarding all newly hired personnel. In the event that application access was added post hire, any changes to user access rights should be documented and approved by appropriate stakeholders.

Management's Response

The ticketing interface between ServiceNow and SailPoint IdentityIQ is in progress. We are awaiting the purchase of the required software and, once purchased, the integration process in place by end of fiscal year 2019.

The current ServiceNow application is keeping track of Qmed and Epic requests and stores all approvals by appropriate stakeholders.

Staus of prior year KPMG Comments

Financial Reporting and Alignment of Finance Resources

Observation

During the year-end audit of NYC Health + Hospitals, we noted inconsistencies in certain balance sheet classifications, footnote disclosures, management's discussion and analysis (MD&A), and required supplemental information.

Recommendation

As part of NYC Health + Hospitals financial reporting process, we recommend the following related to:

- Assess the organizational needs and the available finance staff resources to determine how to best structure the department.
- Perform a formal review of the complete financial statements, inclusive of the financial statements, footnote disclosures, MD&A, and required supplemental information at a level of precision to ensure they are fairly presented. This review should be performed by the Corporate Comptroller prior to submission to KPMG.
- We acknowledge that management utilizes a responsibilities checklist for the year-end close and audit; however, it should be updated to ensure it is up-to-date and covers all significant accounts and relevant disclosures. The updated checklist should ensure that there are reasonable deadlines to allow for the corporate finance department to review and record potential adjustments in a timely manner.
- As a leading practice, prepare a financial statement footnote disclosure checklist, to ensure that all required disclosures are included within the financial statements and in accordance with U.S. generally accepted accounting principles. In addition, management should consider preparing a footnote disclosure and MD&A binder with all relevant documentation provided in one place to support those disclosures.

Management's Response

Management agrees that the use of a checklist for the year-end close will facilitate the completion of the financial statement. Management will also conduct appropriate training of staff to ensure accounting and financial reporting processes, including account analyses are performed to identify significant variances. A final review by the Corporate Comptroller will be completed prior to KPMG receiving the financial statements.

Management's Resolution Status

Management has reorganized the Comptroller's division to support the process of report preparation, review, and submission to the auditors. A complete review of the MD&A, notes to the financial statements, and the pro-forma statements to ensure that the material is complete and accurate is performed before given to the auditors. Management continues to update its internal checklist to facilitate the financial statement process. We are also considering utilizing the KPMG State and Local Government's accounting disclosure checklist.

Patient Accounts Receivable

Observations

1. NYC Health + Hospitals has a process and methodology in place for evaluating the collectability of patient accounts receivable, including a review of the calculation by the Corporate Controller. The process includes an analysis of historical cash collections by payer based only on the Unity patient accounting system and does not include aging categories other than those greater than 365 days. Furthermore, the initial analysis prepared by management did not consider the actual historical collection experience of in-house balances, including large individual account balances, but rather used the collection experience of inpatient billed accounts. Additionally, there was a difference between the patient accounts receivable due to NYC Health + Hospitals from MetroPlus per management's calculation and the estimated MetroPlus liability due to NYC Health + Hospitals. Management recorded an adjustment in the financial statements to patient accounts receivable as a result of properly valuing in-house accounts and the MetroPlus receivable that was not identified by management's initial calculation and methodology.

2. NYC Health + Hospitals currently has approximately $242 million of individual patient credit balances, which are included within the patient accounts receivable, net balance. These credit balances result from overpayments or mis-postings of contractual allowance adjustments. Although management has represented that the majority of the credit balances related to mis-postings of contractual allowance adjustments, a formal analysis has not been performed.

3. During the audit process, we identified significant charges on a single outpatient visit (over $150,000) that was a result of an incorrect quantity being entered into the patient account system. This error was not identified by patient accounting staff at NYC Health + Hospitals during the year and the inflated charges were included in management's analysis when evaluating the collectability of patient accounts receivables.

4. During the audit process we noted that unapplied cash or cash received by NYC Health + Hospitals but not yet applied to the patient accounting system was approximately $99 million at 2017.

Recommendations

We recommend the following:

1. Management should continue to refine its process and methodology in place for evaluating the collectability of patient accounts receivable, ensuring the review is performed at a sufficient precision level to identify any errors. Management's analysis should consider the potential impact of items such as aging, in-house accounts, individually significant balances, and the most recent collection experience from the Sorian patient accounting system. Management should continue to test its process by performing a historical hindsight analysis by comparing subsequent cash receipts to patient accounts receivable at year-end. Management should consider utilizing a data and analytics tools, such as the IDEA program, to assist with its analysis, which would allow them to analyze large volumes of data.

Management should also continue to reconcile the patient accounts receivable from MetroPlus to the estimated MetroPlus liability due to NYC Health + Hospitals. Any significant differences should be investigated.

2. Management should develop a process to review credit balances to determine the potential refund liability and potential impact on patient accounts receivable valuation. This process will be enhanced by management utilizing a data and analytics tool such as IDEA as noted above.

3. Management should develop a process to review significant account balances to determine if any of these balances are as a result of mis-postings and adjust these balances accordingly.

4. Unapplied cash balances should be monitored to ensure that the cash is applied to individual account balances on a timely basis.

Management's Response

Management is planning on purchasing the IDEA software management tool, recommended by KPMG, to assist in the analysis for valuing the accounts receivable. Meetings are being set up with Cerner to develop the data requirements for use with IDEA so NYC Health + Hospitals can transition the valuation techniques to the new software.

The IDEA software will also facilitate a review of credit balances to ensure that they are properly reported in the financial statements as well as identifying accounts with significant balances to assess the appropriateness of such balances. Additionally, Management is refining its process for posting cash to minimize the unapplied cash balances.

Management's Resolution Status

Management purchased the IDEA software management tool and accounting staff have been trained in its use. The software tool is currently being trialed in applying the accounts receivable analysis. Additional work is needed on Sorian and Unity reporting in order to fully utilize IDEA in the valuation of accounts receivable from those systems.

Third Party Reimbursement Estimates

Observation

Management updates and adjusts its financial records based upon calculations and account analysis received by the reimbursement department related to third-party rate reviews and estimates. During our review of the third-party account analysis, we noted that there is no evidence of the formal review that takes place by the Comptroller's office. Additionally, the Controller's office did not obtain and review the source documentation for all significant assumptions.

Recommendation

Given the complexity of the third party reimbursement estimates, we recommended that management develops policies and procedures to ensure a sufficient detailed review of third party reimbursement estimates is performed by the Comptroller's office, which includes obtaining and

reviewing the source documentation for all significant assumptions in order to ensure sufficient appropriate audit documentation exists.

Management's Response

Management agrees with the recommendation and will review the calculations for third-party rate estimates to ensure all documentation is sufficient to support the assumptions used.

Management's Resolution Status

Review of the third-party rate retro packages is prepared by the Corporate Reimbursement office and then proceeds through three rounds of reviews within the Corporate Comptroller's office. Each staff-person tasked with the review completes the sign-off sheet, with final sign-off reserved for the Corporate Comptroller. During the review process, if additional supporting documentation is required, a request is made from the Corporate Reimbursement office.

MetroPlus- Claims

Observation

MetroPlus Health Plan ("MetroPlus") has contractual agreements with healthcare providers, which include agreed upon rates for which MetroPlus will pay the provider for services provided to its members. During the fiscal year-end audit, KPMG selected a sample of individual claims paid to test the accuracy of the claims paid amount to the underlying contractual agreement with the provider. The results of our test work identified differences between the rates in the claims processing system and the underlying contractual agreement for two outpatient providers (one lab company and one optometrist). These differences resulted in overpayments to the providers by MetroPlus. Upon further review by MetroPlus management, it was determined that the accumulated overpayments approximated $40 million, of which approximately $7 million related to the current fiscal year. Management's claims review process failed to identify these overpayments.

Recommendation

We recommend that management enhances its existing policies and procedures in place over claims processing, including contractual rates entered into the claims processing system. For example, management should ensure that all claims are subject to testing, including those that are auto-adjudicated by the system. In addition, Management should evaluate whether its threshold for sampling of all high dollar claims is at a sufficient level for outpatient claims. Management should also ensure its procedures including testing of claims to rates in the contractual agreements.

Management's Response

MetroPlus agrees that the two contracts were initially set up to pay the incorrect fee schedule. The fee schedules utilized were standard for the Plan and at initial view would look to be correct, however, given the errors, the Plan has designed and started implementing enhanced claim payment testing. In addition to the 2016 and 2017 testing enhancements, as well as the immediate review of all Lab and Vision contracts; MetroPlus has implemented a review of vendor contracts with payments over $1 million. To date, 50% have been reviewed with no errors found.

MetroPlus has also enhanced existing testing of manual and auto-adjudicated claims by adding reviews that tie to the contract rate. The MetroPlus Provider Maintenance Unit will now select bi-monthly samples of standard and non-standard provider contracts for review of fee schedule setup. All of these additional efforts will aid the Plan in its quality review process of not only new and amended contracts but of existing contracts in our system. We will work to improve our claims payment process as well as the contract load process to improve outcomes.

Management's Resolution Status

MetroPlus continues to review and enhance processes for contract setup and claim testing accuracy back in line with contract terms. A Contract Group and a Claims Issues Review Group was created to improve the accuracy of our contract setups and related claim payment processes. These two groups meet on a monthly basis to enable key managers and staff to review contract terms and system set ups to enhance claims payment accuracy.

The Claims Department finalized the review of all vendors with payments over $1 million for 2016 and 2017 with no findings and is continuing the review into 2018. The implementation of random claim reviews includes a sampling of vendors that have submitted manual as well as auto-adjudicated claims. These reviews have improved the accuracy of claim payments.

The April 2018 manual sampling produced no findings, but the auto-adjudicated sampling resulted in a finding that one of the six vendors reviewed contained a set up error which produced an underpayment. The contract set up was corrected and the claims were reprocessed for the correct amounts.

The Initial Contract Set-Up review process has also improved the claim payment process. Since its implementation, two contracts were identified with claim payment setup errors and were corrected prior to release to production. MetroPlus utilized this finding to improve the interpretation of contracts during the claims system setup and claims review functions.

The optometrist outpatient provider overpayment that was discovered by KPMG last year has been fully recouped. We are expecting to reach a settlement with the lab outpatient provider in the near future.

MetroPlus- Management Review of Account Analysis

Observations

During the audit, we identified two instances whereby the initial account analysis prepared by MetroPlus was either not updated for the most recent information (stop-loss receivable) or the analysis prepared identified the correction of a previously reported amount (pay-for-performance liability). Management's stop-loss receivable account analysis did not initially consider the most recent collection experience, inclusive of denial activity, which is an important factor used by management to calculate the receivable balance.

In addition, management did not initially include an accrual for amounts that have not been billed, but relate to the fiscal year-end. Management subsequently adjusted the account analysis and recorded adjustments which resulted in a net reduction of $4.6 million to the stop-loss receivable. Management's review of the respective account analysis failed to identify these adjustments. In

addition, management's pay for performance liability account analysis for the current year identified an over accrual of $5 million related to a prior year, which was adjusted in the current year. The adjustments recorded in the current year for the stop-loss receivable and pay-for-performance liability were not considered to be material to the financial statements of NYC Health + Hospitals.

Recommendation

We recommend that management enhances its policies and procedures to ensure timely review of the account analysis to support the balances recorded in the financial statements. This review should be performed by a qualified individual who is at least a level above the preparer and at a level of precision to identify any significant errors.

Management's Response

Stop-loss receivable: MetroPlus will enhance the policies and procedures to review the most recent collection experience and denial activity in the preparation of the stop-loss receivable analysis. In addition, MetroPlus will compute and include an accrual for amounts not yet billed in the analysis. The analysis will be reviewed at a level above the preparer to identify and correct any significant errors on a timely basis.

Pay-for-performance liability: In accordance with MetroPlus' enhanced periodic review and communication process with Health + Hospitals finance staff, MetroPlus will closely monitor the activity in this liability account and all other related accounts to ensure adjustments are recorded within the appropriate fiscal year.

Management's Resolution Status

Stop-loss receivable: MetroPlus has revised its policies and procedures to include the most recent collection experience and denial activity in the preparation of the receivable analysis. This revision has improved the accuracy of the receivable accrual.

Pay-for-performance liability: Our revised communication process with the NYC Health + Hospitals finance staff has resulted in a significantly improved verification process of all related liabilities and other accounts.

Accounts Payable Subledger to General Ledger Reconciliation

Observation

During the prior year and current year audit, KPMG noted that finance at the central office (Comptroller's office) did not have a detailed accounts payable sub-ledger report that reconciled to the general ledger.

Recommendation

We continue to recommend that management obtain a detailed accounts payable sub-ledger report that is periodically reconciled to the general ledger to ensure accuracy of the accounts payable balance. Any unusual reconciling items should be investigated and addressed timely.

Management's Response

The current legacy-based system continues to present reporting challenges due to its lack of adequate management reports. Management believes that the accounts payable activity is properly reported in the general ledger, but agrees that it cannot support the balances through a system report.

NYC Health + Hospitals has begun implementing a new accounts payable system (PeopleSoft Financials) during FY 2018, which is being phased in by facility throughout the fiscal year. When the system is fully implemented, management will be able to support the accounts payable balance in PeopleSoft.

Management's Resolution Status

As facilities have implemented PeopleSoft Accounts Payable in various waves throughout 2018, reconciliations have been developed between the PeopleSoft accounts payable system and the general ledger.

Accounts Payable and Accrued Expenses

Observation

During the audit, we identified one sample related to a capital acquisition that was not recorded as a liability, but rather recorded incorrectly as a capital contribution. Upon further review by management, management identified approximately $26 million of capital acquisitions that should have been recorded as a liability. Management adjusted the financial statements based upon their revised analysis to properly account for the $26 million of capital acquisitions. Management's review process for the recording and classification of capital acquisitions failed to identify the proper recording and classification of capital acquisitions.

Recommendation

We recommend that management implements controls and updates policies and procedures to ensure that purchased goods and services related to capital projects are properly accrued for as liabilities. Additionally, we suggest more frequent communication between the capital planning department and the accounts payable department.

Management's Response

Management agrees with the recommendation and construction in progress ("CIP") will be reviewed by the accounting department to approve all general ledger entries and to ensure that all entries are appropriate and have been recorded accurately. Additional training will also be conducted for the appropriate recording of CIP and other fixed assets.

Management's Resolution Status

Management has added resources in the fixed asset review process to verify accruals are properly reported. A reconciliation of the CIP manual entry to the general ledger will be performed for asset additions and to ensure that the related liability are reported accurately.

Grants Receivable Reconciliation between General Ledger and Grants Sub-ledger

Observation

During the year-end audit we noted that management failed to appropriately reconcile their grants receivable detailed sub-ledger to the general ledger. As a result of our year-end audit procedures, which included reconciling the detailed sub-ledger to the general ledger and inquiring of management, an adjustment of approximately $40 million was recorded to reduce the grants receivable balance.

Recommendation

We recommend that management obtains a detailed grants receivable sub-ledger report that is periodically reconciled to the general ledger to ensure accuracy of the grants receivable. Any unusual reconciling items should be investigated and addressed timely.

Management's Response

Management agrees with the recommendation and will perform detailed account analysis of grants receivable, along with quarterly meetings with the Grants Management department for reviewing all assumptions for completeness and appropriateness.

Management's Resolution Status

On a quarterly basis, the Grants Management department submits a month to month reconciliation of the sub-ledger report which the Comptroller's office reconciles to the general ledger. Any outstanding balances are discussed and corrected, if required, at that time.

Liquidity

Observation

NYC Health + Hospitals continues to face significant challenges pertaining to healthcare reform legislation, changes in federal and state healthcare reimbursement regulations, and continuous managed care market increases. Furthermore, NYC Health + Hospitals relies on funds it receives from Disproportionate Share Hospital ("DSH") fund for serving a large share of Medicaid and low income patients. These DSH funds are to help cover the losses incurred from serving uninsured and Medicaid patients. DSH funds will be subject to federal cuts anticipated to take place in the near future. As a result of the changes in the current economic environment, substantial changes are anticipated in the U.S. healthcare system going forward, which will affect the delivery of healthcare services, the financing of healthcare costs, reimbursement of healthcare providers, and the legal obligations of health insurers, providers, and employers.

NYC Health + Hospitals has reported negative working capital in the most recent fiscal year and operating losses during the most recent two fiscal years, and during 2017 has received approximately $723 million from the City of New York ("the City") in appropriations. Going forward NYC Health + Hospitals will continue to face liquidity constraints and continued financial support will be required from the City as NYC Health + Hospitals continues to fulfill its mission of rendering healthcare services to a substantial number of uninsured patients.

Recommendation

Although, NYC Health + Hospitals has been aggressive in dealing with its financial challenges in a number of ways by creating the Office of Transformation charged with carrying out the goals of "Vision 2020" and Mayor Bill de Blasio's Transformation Plan, we recommend that management and the Board continue to keep their focus on such initiatives and take the necessary actions to ensure that NYC Health + Hospitals' funding remains adequate in order to carry out its vital mission.

Management's Response

Management will continue to support the efforts of "Vision 2020" and the "Mayoral Transformation Plan" toward financial stability and sustainability for providing ongoing healthcare to our communities.

Management's Resolution Status

Management continues to support the "Vision 2020" and "Mayoral Transformation Plan" initiatives. In addition, there has been a change in leadership over the past fiscal period. With the appointment of President and CEO, Mitchell Katz, MD, additional revenue-generating and expense reductions initiatives have been put into place. These initiatives, combined with the Mayoral transformation plan has created a new five-year budget plan balanced through fiscal year 2022 which will further stabilize the health system for the most vulnerable New Yorkers.

Some highlights of the new five-year budget plan include:

- Achievement of more than $250 million in reduced expenses over the past year;
- Continued administrative savings through targeted attrition, managerial reductions, and reduction of consultant costs;
- Strategic investments to grow revenue through the existing patient population;
- Plans to improve billing, contracting, coding and documenting, as well as keeping more MetroPlus business inside NYC Health + Hospitals;
- Expansion of services that are high reimbursement;
- Increased enrollment of uninsured patients into affordable health plans through the City's "Get Covered NYC" initiative and Metro Plus's ongoing enrollment;
- DOCS4NYC campaign – recruitment and retention of more primary care doctors; a key component to the plan to grow patient care revenues

Information Technology - Password Configuration Settings

Observation

During our testing, it was noted that the password configuration settings for Mainframe systems (GEAC and PSMS), OTPS, and the Windows network did not meet industry-leading standards. Specifically, the settings for password minimum length, password expiration, password lockout, and password complexity as noted below:

- Minimum Password Length: A minimum password length of 6 characters does not match the industry standard of 8 characters for the Network and Mainframe applications.

- Password Lockout: For the Network, KPMG found that the configuration setting for password lockout was set to 10 attempts, which did not meet the industry standard of 5 failed login attempts.
- Password History: For Mainframe applications, KPMG found that the configuration setting for password history was set to 0 previous passwords remembered, which did not meet the industry standard of 3 previous passwords remembered. For the Network, KPMG found that the configuration setting for password history was set to 0 previous passwords remembered, which did not meet the industry standard of 3 previous passwords remembered.
- Password Complexity: For OTPS and the Network, KPMG found that complex (Alpha-Numeric) passwords were not required.

Recommendation

We recommend configuring the password settings to industry-leading practices. Management should also update policy to specify password parameters.

Management's Response

Minimum password length – Mainframe Minimum password length is 6 characters. This is currently a minimum password length system limitation. The additional security protocols provided by Active Directory and Web-term logins, required prior to logging into Mainframe and OTPS, help effectively secured these systems.

Based on the recent changes made by the Active Directory team, password complexity has now been implemented. Passwords must contain at least three of the following four character types: uppercase, lowercase, numbers or symbols, and the password must be a minimum of 8 characters, which meets the industry standards. Password history is currently set to 5 (the five (5) most recent unique passwords utilized cannot be recycled until the sixth password change cycle).

We are developing a project that will address the Mainframe and OTPS password and complexity. The Mainframe and OTPS engineering teams will complete their respective projects, of updating their password requirements by 6/30/2018; to meet KPMG's recommended industry standard settings. When completed the Mainframe and OTPS systems will meet the same recommended industry standard settings.

Management's Resolution Status

Minimum Password Length: The mainframe team has implemented a change (July 11, 2018) that will make the minimum password length 8 characters in length. This will meet the Information Security Password and Access Code Standard requirements and the audit recommendation.

Password Lockout: The Active Directory is currently set to 10 attempts, this will be changed to 5 attempts as defined in the Password and Access Code Standards and the audit recommendation as soon as Password Self Service is implemented on or before December 31, 2018.

Password History: The mainframe team implemented a change on July 11, 2018 that changed the configuration for Password History to 5 previous passwords remembered which meets the standards requested.

Password Complexity:

- OTPS: Part of the ERP rollout prerequisite was to keep OTPS basically at status quo. Unless system updates were needed to maintain integrity, the box was to remain as is. OTPS currently has separate login passwords for the OS level and the Cache application level. There is also LDAP authentication required, as well as answerback confirmation between the specific user accounts login, and their application database profiles within Cache. For these reasons alpha numeric password requirements were not enabled at this time.
- Active Directory: Password complexity was implemented on June 15, 2018.

Information Technology - System Access Revocation

Observation

During our testing, it was noted that twenty three employees were not removed from their respective applications in a timely manner (five business days). Additionally, during our test work we noted that none of these twenty three employees accessed the network subsequent to their termination.

Recommendation

KPMG recommends removing terminated users' application level access within 5 business days of effective termination date and that management updates its policy to specify timeliness for terminations.

Management's Response

As of August 4, 2017, PeopleSoft HR became the authoritative source for workforce members. Six times a day, a feed is drawn from PeopleSoft HR and Identity IQ processes that feed and perform onboarding, off-boarding, updates to attributes, transfers and reinstatements. For each terminated employee or consultant an HR or Smart HR representative opens a Remedy SRM that notifies each of the application owners that a user has terminated, in order to meet the KPMG timeliness requirement.

Management's Resolution Status

We are currently using PeopleSoft HR as our authoritative source for all workforce members. All updates are based on the information contained in the authoritative source. When a new user is presented to SailPoint IdentityIQ, we create an Active Directory account, a NYC Department of Technology and Telecommunication ("DoITT") account, an H_20 (account in disabled status), and a ServiceNow account.

Upon receipt of a termination from the authoritative source, SailPoint IdentityIQ will disable the user's Active Directory account, DoITT account, H_20 account, and ServiceNow account.

Note: when the H_20 security team vets a user, their status within SailPoint IdentityIQ is automatically updated to show that the user is active. Only active users are re-certified during the re-certification process.

Information Technology - Periodic Review

Observation

During our testing, it was noted that there is no periodic review of user access in place for Mainframe Systems (GEAC & PSMS), OTPS, and the windows network applications. While the match system provides a way for NYC Health + Hospitals to effectively monitor and terminate inactive accounts, KPMG found that it does not constitute a 'User Access Review' because it does not provide any control over the levels of access each user has within the application.

Recommendation

KPMG recommends that management performs a periodic review of active users and user access rights to identify and remove inappropriate system access.

Management's response

As part of the PeopleSoft HR and Identity Management systems ("Identity IQ") project, we will be working with their teams, as well as the Payroll department personnel, on defining a methodology of assigning a manager or managerial liaison for each of the user's system access identities, in order to create an audit reporting process. The audit report process would include producing periodic reports that would be provided to each of the assigned managers or liaisons, for their review and validation. This will help to ensure each user has the correct access levels and avoid access creep, that may occur when a user job assignment or responsibility changes. We will be working with the Payroll department and facility liaisons, in defining the correct contact personnel to provide the data to and will complete the process by March 31, 2018.

Management's Resolution Status

The Mainframe team is working with the application liaisons responsible for all the facilities and Central Office for their approval of access to all Mainframe and OTPS applications. With reference to the "periodic review" process, we are planning to provide reports to Central Office personnel for their periodic review of access granted. As requested, the team is also working with the OTPS engineers and programmers on generating a modified report of users' security access levels in OTPS. A modified report has been generated (Report 17) which reports users' security access levels in OTPS and is available on demand.

Tax Comment

Observation

Treasury Regulation 1.501(r)-4(b)(5) requires a hospital facility to provide information about its financial assistance policy ("FAP") to patients via conspicuous written notice that informs the recipient about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP and FAP application process and the direct Web site address (or URL) where the copies of the FAP documents may be obtained. KPMG reviewed a sample billing, and noted it references HHC Options and provides a phone number, however the invoice should also provide the website address so patients can read about the FAP online.

Additionally, Treasury Regulation 1.501(r)-5(b) requires a hospital facility to limit the amount charged for care it provides to any individual who is eligible for assistance under its FAP to not more than the amounts generally billed ("AGB") to individuals who have insurance covering such care, and AGB must be determined using one of two methods – the look-back method or the prospective method. Further, the regulations require the hospital facility's FAP to reference its chosen method. In conversations with NYC Health + Hospitals management, KPMG understands NYC Health + Hospitals has not formally adopted the prospective method, nor does it reference either method in their FAP as required by the Treasury Regulations cited above; however, management believes individuals eligible under HHC Options are never charged more than Medicare fee-for-service or Medicaid rates.

Recommendation

We recommend that NYC Health + Hospitals update their billing notices so that they not only include references to HHC Options and a phone number, but also include a website address so patients can read about the FAP online. Additionally, we recommend that NYC Health + Hospitals formally adopt a method and reference it in the HHC Options policy.

Management's response

While Management believes that the existing policies are compliant with New York State regulations, we have informed our billing vendor to add the web address so patients and others can have more information regarding the charity care policy. This process will roll out mid-January 2018. In addition, NYC Health + Hospitals will update the HHC Options policy in regards to Treasury Regulation(s) to describe the method utilized

Management's Resolution Status

Language was added to HHC Options, the NYC Health + Hospitals financial assistance policy, to comply with Treasury Regulation 1.501(r)-4(b)(5), and has been in effect since August 1, 2018. All statement mailers were updated to include the website link for HHC Options, and were put into use in January 2018.

System response

The System's written response to the internal control matters identified herein has not been subjected to our audit procedures and, accordingly, we express no opinion on it.

* * *

The purpose of this communication is solely to describe the scope of our testing of internal control and the result of that testing, and not to provide an opinion on the effectiveness of the System's internal control. This communication is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the System's internal control. Accordingly, this communication is not suitable for any other purpose.

Very truly yours,

GRANT THORNTON LLP

AUDIT COMMITTEE OF THE NYC HEALTH + HOSPITALS BOARD OF DIRECTORS

Audit Committee Meeting

Corporate Compliance Report

December 13, 2018

AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
December 13, 2018 @ 12:00 PM

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AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
December 13, 2018 @ 12:00 PM

I. Monitoring Excluded Providers

Responsibilities of the System for Sanction List Screening

1) To comply with Federal and state regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General ("OMIG")[1] 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

2) To ensure that the System does not conduct business with individuals or entities that are a threat to the security, economy or foreign policy of the United States, the OCC also screens all NYC Health + Hospitals workforce Members, vendors and DSRIP Partners against the databases of the United States Department of Treasury Office of Foreign Asset Control ("OFAC").[2]

Exclusion and Sanction Screening Report October 1, 2018 through November 30, 2018

3) During the period October 1, 2018 through November 30, 2018, there was one excluded individual and follow up regarding a previously identified excluded individual.

4) On October 16, 2018, the OCC was notified that a patient care associate at NYC Health + Hospitals/Lincoln appeared on the System for Award Management ("SAM") list as having been excluded by the Department of Education. She was excluded due to her lack of business honesty or integrity, pending completion of an investigation/legal proceeding. The individual was terminated on October 16, 2018, and, according to advice of counsel, there was no overpayment issue for this individual because she had not been excluded by the OMIG or the OIG from participation in the Medicare or Medicaid programs.

[1] *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)).
[2] *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) The previously identified excluded individual was a human resources administrator at NYC Health + Hospitals/Kings ("Kings) who was provided to NYC Health + Hospitals through a staffing agency. The OCC was informed about the individual's exclusion on July 31, 2018. She worked at Kings from April 2018 through the end of July 2018. After investigation, the OCC reported an overpayment to the OMIG, and the possibility of an overpayment to National Government Services.

Death Master File and National Plan and Provider Enumeration System Screening

6) The Centers for Medicaid and Medicare Services' ("CMS") regulations[3] and the contractual provisions found in managed care organization provider agreements[4] require screening of the System's workforce members, certain business partners, and agents to ensure that none of these individuals are using the social security number ("SSN") or National Provider Identifier ("NPI") number of a deceased person. This screening may be accomplished by vetting the SSNs and NPIs of such individuals through the Social Security Administration Death Master File ("DMF") and the National Plan and Provider Enumeration System ("NPPES"), respectively.

7) No providers were identified on the DMF or NPPES during the period October 1, 2018 through November 30, 2018.

II. Privacy Incidents and Related Reports

Reported Privacy Incidents for the period of October 1, 2018 through November 30, 2018

8) During the period of October 1, 2018 through November 30, 2018, thirteen privacy incidents were entered into the RADAR Incident Tracking System. Of the thirteen (13) incidents, four (4) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures ("OPs");

[3] *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.

[4] *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)").

two (2) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures; and seven (7) are still under investigation. Of the four (4) incidents confirmed as violations, three (3) were determined to be breaches.

Breach Defined

9) 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.[5]

10) Pursuant to 45 CFR § 164.402(2), the unauthorized use and/or disclosure of PHI is presumed to be a breach unless an exception applies or 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.[6]

Reported Breaches for the Period of October 1, 2018 through November 30, 2018

11) As stated above, there were three (3) reportable breaches between October 1, 2018 and November 30, 2018, which are summarized below.

- **NYC Health + Hospitals/ Jacobi – October 2018**

Incident: On October 5, 2018, the OCC was notified of the incident, which occurred when NYC Health + Hospitals' vendor, CIOX, sent patient records, including information about the patient's medical history, diagnoses, medications, to the wrong courthouse. This incident occurred prior to CIOX's audit and Quality Assurance activities, as described *infra*.

Breach Determination: Even though it is customary for the courthouse that received the misdirected records to transfer any such records to the correct courthouse, the courthouse that received the misdirected records could not confirm that the records were in fact received and appropriately transferred to the correct courthouse. The

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

breach notice was sent on November 14, 2018. The records were subsequently sent to the appropriate requestor.

Mitigation: According to the vendor, the responsible employee received training from the vendor on unauthorized disclosure prevention, and was subject to a corrective action plan.

- **NYC Health + Hospitals/ North Central Bronx ("NCB") – October 2018**

Incident: On October 2, 2018, the OCC was notified of an incident, which occurred on September 27, 2018, when a NCB care manager accessed the records of his friend/acquaintance. The care manager claimed that the patient requested his assistance, he accessed the records with the patient's consent, and the nature of his job as a care manager would have allowed him to access the chart of any patient in that manner if the patient requested his assistance.

Breach Determination: It was determined after investigation that the employee was not working on the unit at the time of the incident, and did not have a legitimate business reason for accessing the patient's chart. The patient in question could not be reached to obtain confirmation that she verbally agreed to the care manager accessing her chart. The breach notice was sent on November 20, 2018.

Mitigation: The employee had a Step 1A disciplinary hearing before Labor Relations, which remanded the case to the department for the department to issue a written warning, which was placed in the employee's personnel file. The employee was also counseled about patient privacy and proper protocol when a family member or friend is a patient.

- **NYC Health + Hospitals/Bellevue ("Bellevue") – October 2018**

Incident: This incident was brought to our attention on October 11, 2018, and occurred when Patient Relations at Bellevue received a report from a patient stating that in 2017 he received medical records for another patient. After an investigation into the incident, it was determined that the patient had requested the records in 2015, that the envelope containing the records was not opened until 2017, and not reported

until October 2018. It appears that the incorrect release of records occurred due to the similarity in last names.

Breach Determination: Of the four key factors described above, the nature and extent of the PHI involved, and the inability to completely 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 November 2, 2018.

Mitigation: The OCC worked with the patient who reported the incorrect disclosure to ensure that the records had been destroyed appropriately and that no other individuals had viewed or obtained any information from the records.

Office for Civil Rights ("OCR") Inquiries Regarding Privacy Incidents

12) There was one inquiry initiated by the OCR between October 1, 2018 and November 30. 2018. The inquiry pertained to an incident which occurred at NYC Health + Hospitals/Elmhurst ("Elmhurst"). On November 5, 2018, the OCC was notified via a letter from the OCR (Transaction 18-306394) that an individual filed a complaint with the OCR stating that he/she had been receiving documents, including bills and behavioral health appointment reminders, addressed to a patient from Elmhurst. The complainant also noted that attempts with Elmhurst's Patient Relations and Billing Departments to correct the issue went unresolved. After investigation by the OCC, it was determined that the patient to whom the records belonged had presumably provided an incorrect address, which was changed immediately in Elmhurst's records. Attempts to reach the patient have thus far been unsuccessful.

CIOX Audit Results

13) As reported at the October 2018 Audit Committee meeting, one of our vendors, CIOX, which responds to medical records requests on the System's behalf, was responsible for ten (10) HIPAA breaches this year. Consequently, the Chief Corporate Compliance Officer ("CCO") had a conversation with CIOX's Chief Privacy Officer to discuss what CIOX is doing to avoid further breaches. She informed the CCO that CIOX was implementing the following corrective actions:

- Performing a 100% quality assurance check on records requested from Bellevue and Jacobi, from which the majority of the breaches came, to ensure that the correct documents are being sent to the correct requester;
- Conducting unannounced on-site audits of their workforce at Bellevue and Jacobi to determine whether they are following proper policies and procedures, and HIPAA requirements; and
- Developing an action plan based on the results of the audits to bring their workforce into compliance.

In addition, the Office of Supply Chain engaged a consulting group to review CIOX's services and determine whether there are opportunities for improvement or change. Currently, the facility Health Information Management ("HIM") Directors oversee CIOX's services; however, we are in the process of centralizing this function. In the meantime, the Office of Supply Chain has identified a temporary point person to act as a liaison between CIOX and the HIM Directors until this function transitions to finance.

14) On December 3, 2018, CIOX sent the CCO the results of its audits at Bellevue and Jacobi. The OCC is awaiting for the resulting of the Quality Assurance review. Among the findings of the audits were the following:

- Staff need retraining on multi-factor patient identification when multiple names and dates of birth occur;
- Bellevue is a high risk site for sensitive patient information, and many of CIOX's staff at Bellevue have limited experience, including the site supervisor and area supervisor;
- The site supervisor at Bellevue appears to be unqualified for the position, due to lack of available candidates with qualifying experience in management and health care; additional training is being provided and CIOX will perform additional Quality Assurance on his work and review it with him;
- There is a printing issue at Bellevue that results in portions of prior print jobs printing in the middle of a subsequent print job, causing two patients' information to be combined into one print job;

- CIOX needs to continue to monitor both sites for Quality Assurance and potentially conduct another site audit at Bellevue in 2019; and
- NYC Health + Hospitals' unauthorized disclosure concerns, unqualified supervisor, and lack of further management oversight allowing the HIM Director to direct workflow and quality presents numerous risks associated with CIOX policy and compliance with regulations.

15) In addition, the Office of Supply Chain has attempted to meet with the consulting group, CIOX, and the HIM Directors to discuss the consultant's findings; unfortunately, two scheduled meetings had to be cancelled due to conflicts. The next meeting is scheduled for December 19, 2018.

Update on Policy for Securing Biomedical Devices

16) As previously reported, there was a breach of PHI at Harlem that resulted from the theft of a laptop from the hospital's Audiology Department. During the discussion regarding this breach, the OCC reported that it would be working with Enterprise Information Technology Services ("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.

17) Since the October 15, 2018 Audit Committee meeting, a group comprised of representatives from EITS, Supply Chain, Acute Care Operations, and the OCC met to discuss the development of a Biomedical Device Operating Procedure ("OP"). As a result, a Draft Biomedical Device OP was prepared by the OCC, and circulated to the group for review. Following final review of the Draft OP, it will be distributed to the appropriate departments for review and comment, before the final version is sent to the President for approval and signature. If approved, additional resources will be required to implement.

18) The next step in this process is to identify an enterprise-wide Biomedical Task Force, as described in the Biomedical Device OP. The Biomedical Device Task Force will be a multidisciplinary group with responsibility for:

- Oversight and monitoring of all biomedical device management processes, including the Biomedical Device OP; and

- Oversight and management of all biomedical devices, including on-boarding, inventory, and encryption.

19) The Biomedical Task Force will be comprised of senior leadership representation from the OCC, EITS, Office of Supply Chain, Clinical Engineering, operations, and other stakeholders as needed.

20) In addition, EITS is working on revising a 2010 Device and Media Control Plan, which addresses the receipt, movement, and removal of devices and electronic media that contain electronic health information into, within, and out of NYC Health + Hospitals. The revisions should be completed by the end of this week.

III. Compliance Reports

Summary of Reports for the Period of October 1, 2018 through November 30, 2018

21) For the period October 1, 2018 through November 30, 2018, there were seventy-nice (79) compliance reports, none of which were classified as Priority "A," [7] twenty-one (21) (27%) were classified as Priority "B," and fifty-eight (58) (73%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints. The seventy-nine (79) reports were received from the below-listed sources:

a. PRIMARY ALLEGATION SOURCES

SOURCE

	Total	Frequency (Percentage)
E-Mail	10	12.7
Hotline	29	36.7

[7] 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.

Telephone	4	5.1
Mail	3	3.8
Website	1	1.3
Voicemail	1	1.3
Web Submission	31	39.2
Total	**79**	**100**

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	4	5.1
Employee Relations	27	34.2
Environmental, Health and Safety	4	5.1
Financial Concerns	4	5.1
Misuse or Misappropriation of Assets or Information	9	11.4

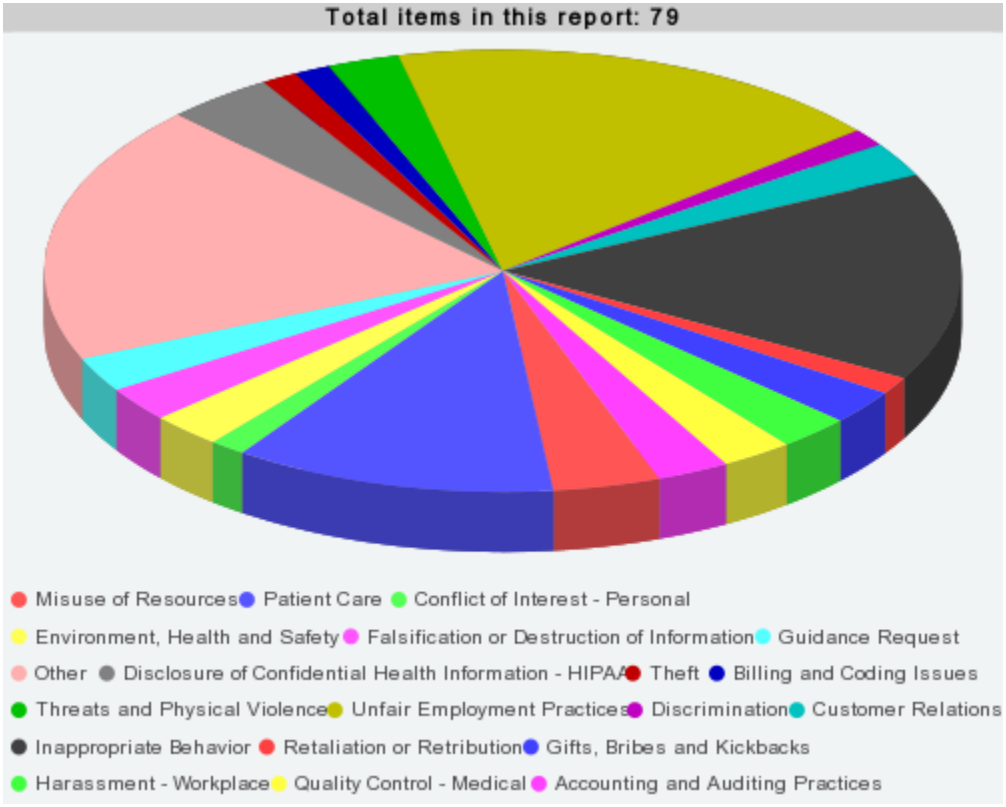
Other	17	21.5
Policy and Process Integrity	14	17.7
Total	**79**	**100**

c. PRIMARY ALLEGATION TYPE

PRIMARY ALLEGATION TYPE

	Total	Frequency (Percentage)
Misuse of Resources	3	3.8
Patient Care	9	11.4
Conflict of Interest - Personal	1	1.3
Environment, Health and Safety	2	2.5
Falsification or Destruction of Information	2	2.5
Guidance Request	2	2.5

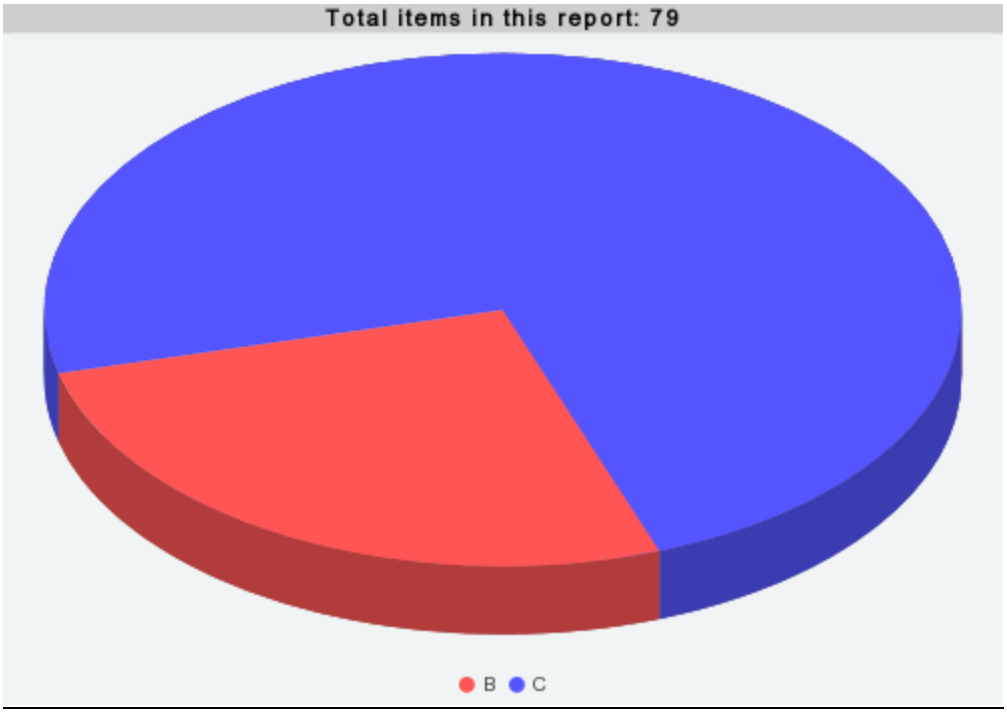
Other	15	19
Disclosure of Confidential Health Information - HIPAA	3	3.8
Theft	1	1.3
Billing and Coding Issues	1	1.3
Threats and Physical Violence	2	2.5
Unfair Employment Practices	14	17.7
Discrimination	1	1.3
Customer Relations	2	2.5
Inappropriate Behavior	12	15.2
Retaliation or Retribution	1	1.3
Gifts, Bribes and Kickbacks	2	2.5
Harassment - Workplace	2	2.5
Quality Control - Medical	2	2.5
Accounting and Auditing Practices	2	2.5
Total	**79**	**100**



d. PRIORITY CLASSIFICATION

PRIORITY

	Total	Frequency (Percentage)
B	21	26.6
C	58	73.4
Total	**79**	**100**



IV. Status Update – DSRIP Compliance Activities

Audit of OneCity Health DSRIP Program by Outside Auditor

22) As previously reported, OneCity Health engaged a third-party auditor, Bonadio & Co., LLP ("Bonadio"), to audit OneCity Health's internal processes, including Partner selection and contracting, quarterly reporting, funds flow, and the Partner

portal. Bonadio completed its audit of OneCity Health, and submitted its final audit report to the Board of Directors of OneCity Health on October 9, 2018. During a subsequent internal meeting with the Comptroller's office, Internal Audits, and the OCC, it was determined that modifications should be made to two of Bonadio's findings in its report. Bonadio's final report has not yet been submitted to the OneCity Health Board of Directors. It should be noted that, on December 5, 2018, the New York State Department of Health ("DOH") broadcast an email to other PPSs acknowledging OneCity Health for conducting this audit, which DOH considered a best practice, and advising other PPSs that they should consider doing the same.

V. Status Update - HHC ACO, Inc.

23) As previously reported, on October 5, 2017, HHC ACO, Inc. ("HHC ACO") submitted an application to the New York State Department of Health ("DOH") seeking approval for an "all payer" ACO, which includes Medicaid, commercial insurance, and Medicare Advantage patients. That application is still pending.

24) On August 9, 2018, the Centers for Medicare and Medicaid Services ("CMS") issued a proposed rule for CY2019 of the Medicare Shared Savings Program ("MSSP"), which sets forth a number of proposed changes to the MSSP, including changes that encourage ACOs to take on greater risk. The final rule is expected to be released later this year.

25) Recently, CMS announced that the ACOs may elect to extend their participation agreements for six months. CMS is permitting this extension to allow ACOs more time to implement two-sided risk arrangements. HHC ACO has therefore elected to extend its participation agreement with CMS through June 30, 2019.

26) HHC ACO expects to move into a two-sided risk contract beginning July 1, 2019, and expects to know more information after CMS issues the final MSSP regulation in 2019.

VI. Aetna Desk Review

27) As previously reported, 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.

28) On April 30, 2018, the OCC received Aetna's Compliance Program Elements Audit Report (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 corrective action plans to Aetna for the failed compliance requirements, which the OCC did on May 25, 2018.

29) On August 27, 2018, the OCC submitted NYC Health + Hospitals' report on the implementation of its corrective actions plans, most of which involved changes to Operating Procedures. On September 18, 2018, the OCC received an email from Aetna requesting additional information in response to one of the System's corrective action plans, which the OCC provided on September 20, 2018.

30) On November 15, 2018, the OCC received an email from Aetna regarding its further review of the System's corrective action plans, stating that the System needs to revise its policies to meet a record retention requirement that the OCC believes does not apply to the System. The OCC is conferring with the Office of Legal Affairs regarding the System's obligation to comply with this requirement.

VII. FY2018 Corporate Risk Assessment & FY2019 Corporate Compliance Work Plan

Regulatory Requirements

31) The FY2018 Corporate Risk Assessment ("Risk Assessment") was undertaken pursuant to NYS Social Services Law ("SSL") § 363-d(2)(f) and its implementing

regulation, 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*, and it conducted annually.

32) OP 50-1 provides that the 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

33) The OCC identified various risks to the System, broken down by service line (*e.g.* acute care, post-acute care, etc.) and System-wide. 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.[8]

34) The risks described in the Draft Risk Assessment were derived from the OMIG's Work Plans, and the OIG's 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 the Draft Risk Assessment were identified internally.

35) Following the ECW's review, the Draft Risk Assessment was presented to the Compliance Committees of the System's facilities, entities, and programs for their input and identification of additional risks pertinent to their facilities, units, entities, or programs. The Compliance Committees were asked to rank each of the relevant risks as high, medium or low.

[8] The Risk Assessment did not include risk assessments of OneCity Health, HHC ACO, Inc., or Correctional Health Services, all of which are being conducted separately.

36) The OCC then finalized the Risk Assessment and identified the impact, vulnerability, and current controls associated with the identified risks, and assigned a severity rating to each risk on a scale of 1 – 5, with 5 being the risks having the greatest impact. The OCC utilized a *Table of Risk Assessment Scoring Parameters,* adopted and derived, in pertinent part, from the Health Care Compliance Association, to score and prioritize the identified risks.

37) Once all the risks were prioritized, the OCC developed a Draft FY2019 Corporate Compliance Work Plan ("Draft FY2019 Work Plan"), which included the risks from the Risk Assessment with the highest risk prioritization scores in each service line and System-wide. On September 10, 2018, the ECW met to review and discuss the draft FY2019 Work Plan. As a result, the ECW identified certain issues in the Draft FY2019 Work Plan for which follow-up was necessary.

38) On November 26, 2018, the ECW met to discuss the follow-up to the Draft FY2019 Work Plan, and to finalize the FY2019 Corporate Compliance Work Plan for submission to the System President and Chief Executive Officer and the Audit Committee for approval. The FY2019 Corporate Compliance Work Plan will be ready for submission to the President and to Audit Committee for approval on December 13, 2018.

VIII. Records Management

Current Situation

39) As previously reported, in May 2018, a Records Task Force was formed to address the issue of more than 621,000 boxes of paper-based files in off-site storage at Iron Mountain, at a monthly storage rate of more than $335,340, and annual storage rate of more than $4,024,080. The Records Task Force was comprised of the System's Corporate Records Management Officer ("RMO"), and representation from the OCC, the Office of Supply-Chain, the Office of Legal Affairs ("OLA") and EITS. The mandate for the Records Task Force was to deal with the immediate problem of the excessive storage at Iron Mountain, and to establish a plan for the future of records management for the System.

40) To date, 61,310 of the 621,000 boxes have been identified for destruction due to the age of boxes based on their in-take dates, and the type of records contained therein (*i.e.* non-clinical records excluding human resource records). The RMO will submit a request for destruction approval for these boxes to the System's senior leadership, explaining the analysis and the methodology used to determine the need for destruction, along with the costs associated with storing such boxes. Once approval is obtained, the RMO will work with Iron Mountain and the Office of Supply Chain to destroy these boxes.

41) In addition, 77,359 of the 621,000 boxes have an identified destruction date that was entered by a System workforce member. Destruction of these records will follow the standard destruction process outlined in OP 120-19, *Corporate Records Management Program and Guidelines for Corporate Record Retention and Disposal.* We are on track to order destruction of the majority of these boxes within the next couple of months.

42) In total, therefore, there are approximately 138,700 boxes that can be slated for destruction, which would save the System approximately $74,898 monthly, and approximately $898,776 annually.

Next Steps & Future State of Records

43) After a series of meetings with Iron Mountain, the RMO, in conjunction with the Office of Supply Chain, was able to put in place the following immediate steps to curb the mounting storage at Iron Mountain:

- No additional boxes will be sent to Iron Mountain.
- Restrict individual facility records management activities, including sending boxes off-site, to one or two Facility Records Officers per site, who will work with the RMO. Note that a total of over 600 NYC Health + Hospitals workforce members have been interacting with Iron Mountain regularly, often ending boxes off-site with no labelling and no retention dates.
- With the help of the Facility Records Officers, begin identifying records at Iron Mountain that have no retention requirements and/or are past their retention period.

44) In early September, the RMO along with the Office of Supply Chain met with EITS to plan for digitization of records. In subsequent meetings, EITS presented the software solution OnBase to the Records Task Force, which can be used as an enterprise content management system ("ECM"). Among other things, an ECM provides functionality such as indexing and labelling of digitized records, recording meta-data pertaining to the records, and manual or auto-purging of records past their retention period.

45) On November 15, 2018, the RMO presented to the EITS Intake Meeting NYC Health + Hospitals' records digitization initiative as the System's future state for records retention strategy. At the meeting, the EITS project management committee voted to advance the digitization initiative to the Health Information technology ("HIT") Committee, and assigned a project manager to the initiative. If the digitization initiative is accepted and voted upon as a "high priority" project at the upcoming HIT Committee meeting, the initiative will become an "IT Project" which will be tracked and assigned technology resources.

IX. Workforce Member Compliance and HIPAA Training

Overview of NYC Health + Hospitals' Compliance and HIPAA Training

46) Compliance and HIPAA training is provided to all NYC Health + Hospitals' workforce members, including Members of the Board of Directors, as required by state law and regulation and OP 50-1 *Corporate Compliance and Ethics Program*. Generally, such training is provided electronically through the System's PeopleSoft Enterprise Learning Management System ("ELM"). Such training also includes in-person, introductory training by Compliance Officers for new workforce members on their orientation day(s), on a monthly basis at all hospitals and skilled nursing facilities, and at central office. Targeted and specific Compliance and HIPAA training is also provided throughout the year as needed.

Updates to NYC Health + Hospitals' Compliance and HIPAA Training

47) Over the last year, the OCC has made significant revisions and updates to how the System provides Compliance and HIPAA training and education to its workforce

members. The revisions and updates were designed to enhance and ease the training and education process, while simultaneously meeting regulatory requirements in a more efficient and expeditious manner. The following is a brief summary of the OCC's efforts to enhance the training and education process:

- Combined previously separate annual courses (*i.e.* Compliance and HIPAA) into one Human Resources Annual Mandates training curriculum – making it easier for workforce members to meet regulatory requirements in one step;
- Developed a similar yet separate course for new workforce members, thus allowing a clear distinction of completed required orientation training, which is now maintained in their records;
- Developed "tracks" in both online courses which are more specific to the workforce member's role at NYC Health + Hospitals (*e.g.* physician track, non-clinical workforce member track, and volunteer/student track);
- Replaced previous in-person/live training with ELM training, which has allowed Compliance Officers to dedicate more time to other critical compliance activities;
- Worked with Human Resources Shared Services ("HRSS") and Workforce Development to produce a new online course for the purpose of remedial education of workforce members when a HIPAA incident and subsequent investigation warrants such. This online course, previously provided on paper, allows for better tracking, reporting and documenting of steps taken to mitigate future issues; and
- Worked with HRSS to offer, for the first time, in June and July 2018, a method of online training for the incoming class of resident physicians across the System. More than 1,800 residents were able to complete their training and education obligations prior to their start date, which lead to a faster and more seamless assignment of their clinical duties. This lead to a completion rate within the first week of on-boarding of close to 97%.

Board of Directors Compliance Training

48) In accordance with New York State Social Services Law and regulation, and consistent with NYC Health + Hospitals' OP 50-1, *Corporate Compliance and Ethics Program*, as part of the Systems' compliance program, governing body members are required to receive compliance training. Accordingly, the OCC provided an in-person Compliance and HIPAA Training on November 29, 2018 for Members of the Board of Directors. Those not present at such training will be able to take the Compliance and HIPAA Training course via video.

National Corporate Compliance and Ethics Week 2018

49) The OCC commemorated National Corporate Compliance & Ethics Week, which was held this year from November 5th to 9th. This year's Corporate Compliance and Ethics Week theme, ***Awareness, Recognition, Reinforcement,*** embodied key elements of the OCC's work towards increasing the prominence of compliance concerns, acknowledging the duty to report them, and emphasizing the importance of professional and ethical conduct in carrying out our duties and responsibilities.

50) National Corporate Compliance and Ethics Week was an opportunity for workforce members across the System to learn more about compliance and ethics at NYC Health + Hospitals through outreach and education, thus fostering their support for and commitment to the culture of compliance and ethics. In addition, the week provided an opportunity to "meet and greet" their local compliance officers.

51) Compliance Officers worked to promote events at across the System, including at acute care facilities, skilled nursing facilities, central office locations, and NYC Health + Hospitals/At Home, as well as at the neighborhood health centers. Workforce members were greeted with educational and informational handouts and promotional items. In addition, for the first time in recent history, the OCC offered an electronic "Word Scramble" for users to participate in remotely for a chance to win a prize. The OCC is pleased to report that hundreds of workforce members participated in these various events each day.