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AUDIT COMMITTEE
MEETING AGENDA

February 14, 2019
10:00 A.M.

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

CALL TO ORDER	Ms. Helen Arteaga Landaverde
• Adoption of Minutes December 13, 2018	Ms. Helen Arteaga Landaverde
INFORMATION ITEMS	
• Audits Update	Mr. Chris A. Telano
• Compliance Update	Ms. Catherine Patsos
OLD BUSINESS	
NEW BUSINESS	
ADJOURNMENT	

MINUTES

AUDIT COMMITTEE **MEETING DATE: December 13, 2018**
TIME: 12:00 P.M.

COMMITTEE MEMBERS
Mitchell Katz, MD
Gordon Campbell
Helen Arteaga Landaverde, MPH

STAFF ATTENDEES
Andrea Cohen, Acting General Counsel, Legal Affairs
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
Kim Mendez, Chief Health Information Officer
Yvette Villanueva, Vice President, Human Resources
Jay Weinman, Corporate Comptroller
Janet Karageozian, Assistant Vice President, EITS
James Linhart, Deputy Corporate Comptroller
Catherine Patsos, Compliance Officer
Devon Wilson, Senior Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Nicole Fleming, Controller, Central Office
Beverly Addai, Senior Accountant, NYC H+H/Metropolitan
John L. Cuda, Chief Financial Officer, 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.

Office of State Comptroller: Justine DeGeorge

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DECEMBER 13, 2018
AUDIT COMMITTEE MEETING
MINUTES

Call to Order

The meeting was called to order at 12:07 P.M. by Mr. Gordon Campbell, Audit Committee Member. Mr. Campbell stated that as soon as Mr. Katz arrives, we will move to adopt the minutes of the Audit Committee meeting held on October 15, 2018.

Fiscal Year 2018 Draft Financial Statements

Mr. Campbell introduced the information item regarding the Fiscal Year 2018 Draft Management Letter.

Grant Thornton Management Letter

Ms. Radinsky presented by outlining the observations and recommendations.

Unlike a public company, we do not provide an opinion on internal control, under our professional standards noted on the Financial Statements issued in November 2018, we give an understanding of the control requirements, our processes and we do certain testing of the controls to support our process.

There are three levels of internal control deficiencies:

1. Control deficiency (lowest level) – exists when the design or operation of a control does not allow management or employee, in the normal course of performing their assigned functions, to prevent or detect and correct, misstatement on a timely basis.
2. Material weakness (highest level) – 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 statement will not be prevented or detected and corrected, on a timely basis.
3. Significant deficiency (middle category) – less severe than the material weakness, but it is important enough to warrant the attention of the Board and this Committee and those people in charge of governance.

Accounts Payable

Significant Deficiency – During fiscal 2018, New York City 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 did not reconcile to the general ledger old system.

We recommend that management put controls at an appropriate level of precision to prevent misstatement of the accounts payable balance and continue 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.

Mr. Weinman added that this comment relates to the old system. Since the implementation of the ERP, at the end of this year, we are not going to have balances related to the old system. All vendor payables will be in the new system as they are today and are already reconciled. We have accepted this comment, it is a long-standing comment that KPMG had for many years that the old system did not have adequate reports to reconcile. The adjustment made is immaterial to the financial statements and we recognized the need to move to a new system.

Patient Accounts Receivables and Net Patient Service Revenue – Credit Balances - we noted that credit balances in patient accounts receivable totalled approximately $80 million. We recommend that management develop 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 while they are current. We understand that there is an EPIC system that the credit balances are being tracked electronically and routed to the appropriate people to investigate.

Dr. Katz asked what causes a credit balance in our system.

Mr. Weinman answered that for a single patient who has many visits, a payment for a visit was posted to a different visit that would cause an open balance for a visit and an overpayment to different visit.

Dr. Katz added that this should be routed to the appropriate department to make sure that the appropriate payment is applied to the account.

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

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. This immaterial does not reflect the financial statements as a dollar value.

We recommend that management develop 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.

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

We noted two high dollar manual adjustments to patient account balances that were made in error. 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. NYC H+H is in the process of 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.

<u>Information Technology</u>

We performed systematic and automated controls that relate to the systems in place. We concentrated on the financial dependent systems; PeopleSoft, Unity and Sorian. We have a few comments related to information technology:

1. Unidentifiable Users – we identified one person having a Network administrator account that was not listed as an employee or outside consultant. 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 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.
2. Segregation of Duties – We noted that a couple of PeopleSoft security administrators have access to source code and to modify production. 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 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. Management will implement audits of these pre-existing logs going forward.
3. Sharing Account – we noted that 'sysadmin' account on the PeopleSoft database is shared by the PeopleSoft Administrators team and the Database Administrators team. 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 agrees with the recommendation and, moving forward, will request that all individuals associated with Database Administrator and/or PeopleSoft Administrator teams maintain individual accounts.
4. User Access Review – 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. We recommend management performs a comprehensive review of user access entitlements on a regular basis (i.e., at least once per fiscal year).
5. User Administration: New Hires - 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. 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 responded that 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 will be in place by end of fiscal year 2019.

CORPORATE COMPLIANCE UPDATE

Ms. Patsos began her update with Monitoring Excluded Providers -

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

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

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 there is no overpayment issue for this individual because she has not been excluded by the Office of the Medicaid Inspector General or the Office of Inspector General from participation in the Medicare or Medicaid programs.

Death Master File and National Plan and Provider Enumeration System Screening

The Centers for Medicaid and Medicare Services' ("CMS") regulations and the contractual provisions found in managed care organization provider agreements 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. There no providers identified.

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

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"); 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.

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

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.

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

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 employee had a Step 1A disciplinary hearing before Labor Relations, which remanded the case to the department to issue a written warning, which was placed in the employee's personnel file.

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. 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 of Civil Rights ("OCR") Inquiries Regarding Privacy Incidents

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

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.

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.

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

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.

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.

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.

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.

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

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. Most of them had to do with employees' relations and a lot of them had to do with disgruntled employees.

Audit of OneCity Health DSRIP Program by Outside Auditor

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.

Status Update - HHC ACO, Inc.

1) 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.
2) 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.
3) 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.
4) 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.

Aetna Desk Review

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.

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 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.

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.

FY2018 Corporate Risk Assessment & FY2019 Corporate Compliance Work Plan

The Risk Assessment Process

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.

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.

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.

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.

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.

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.

Records Management

Current Situation

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.

To date, 61,310 of the 621,000 boxes have been identified for destruction due to the age of boxes based on their intake 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.

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.

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.

Ms. Arteaga Landaverde asked if the 138,700 boxes slated for destruction are part of the annual destruction.

Ms. Patsos answered no that these boxes have been there for a long time. If these boxes are non-clinical records and non-HR records, they can be destroyed.

Dr. Katz commented that ideally if they all could be destroyed, because of the value of keeping unindexed boxes is very low. If they are all destroyed, there will not be any HIPAA issues. If someone requests a record and does not return it, then it becomes an issue. If they are not going to be destroyed, why we are renting space, we have lots of space. Maintaining records only requires a secured locked place.

Ms. Patsos stated that it has come up, but aside from the secured place, it needs the proper environment for the records.

Dr. Katz asked at what point we can have these records digitized.

Next Steps & Future State of Records

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 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.

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.

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.

Ms. Patsos added that we would like to scan all of the boxes and we are evaluating the cost.

Dr. Katz stated that it's an expensive solution relative to moving it out of storage and putting it on one of our hospitals' locked spaces. Going forward it makes sense, but going backwards, it makes no sense giving our clinical priorities.

Mr. Campbell asked Mr. Lynch going forward, how would they be stored digitally?

Mr. Lynch answered that it is still to be determined.

Updates to NYC Health + Hospitals' 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. 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%.

Mr. Campbell 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 1:04 P.M.

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OFFICE OF INTERNAL AUDITS

AUDIT COMMITTEE BRIEFING
FEBRUARY 2019

Index

A. EXTERNAL AUDITS

1. *Controls Over Equipment – Office of the State Comptroller*

Audit Notification Letter Received – December 5, 2017
Entrance Conference – December 20, 2017
Exit Conference – August 6, 2018
Final Draft Report – Received September 27, 3018; responses issued within 30 days
Final Report - Received January 9, 2019

The Office of the State Comptroller commenced their audit of Controls over Equipment on the day of the entrance conference. The objective of the audit included a physical verification of assets, and the review of the Fixed Asset System and asset disposal procedures.

After obtaining background information from Corporate Finance, the Auditors visited nine NYC Health + Hospitals facilities to review their processes related to equipment. They also met with EITS and Corporate Operations to discuss the controls in effect over their equipment procurement and maintenance processes. Testing was conducted at the following 9 facilities:

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

The final report stated that the Auditors observed physical controls, including security personnel and cameras, during their facility visits and located most equipment listed in the Fixed Asset Management system (FAM). Overall, H+H officials could not account for 18 of the 263 sampled items, which had a book value of $17,924 as of June 30, 2017. In addition, record keeping issues within FAM were noted during their review.

The Auditors recommended that action be taken to improve certain procedures related to FAM, repair of assets, and tracking and monitoring of equipment. The appropriate action was taken by Finance management to comply with the suggested improvements.

2. ***Compliance with Federal Tax Requirements – Internal Revenue Service***

Audit Notification Letter Received – August 30, 2018
Entrance Conference – October 30, 2018
Audit Status – On-going

After being on-hold during the government shutdown, this audit re-started on January 28, 2019. The objective of the audit is to ensure compliance with federal tax requirements as an exempt organization. During the entrance conference, the IRS requested the following documents:

a) Financial Assistance Plan (FAP) for each hospital facility – this document must apply to all emergency and other medically necessary care provided by the hospital facility and include:

- Eligibility criteria for financial assistance and whether such assistance includes free or discounted care.
- The basis for calculating amounts charged to patients.
- The method for applying financial assistance in the case of a hospital that does not have a separate billing and collection policy.
- The actions that may be taken in the event of nonpayment.
- The measures taken to widely publicize the FAP within the community served by the hospital.

b) Minutes from meetings describing the FAP during FY16, the billing and collection policy and actions taken in the event of nonpayment of fees.

c) Community Health Needs Assessment (CHNA) for FY16 - which is required to be conducted by each hospital facility once every three years in order to document the extent to which it understands the unique characteristics and needs of the local communities it serves, and responds to these means by delivering meaningful and effective benefit through clinical services.

The Financial Assistance Plan (FAP) for each hospital facility was provided to the IRS on November 1, 2018 by Revenue Management. Based on the FAP that was provided, a second 'Information Documentation Request' was submitted to the Office of Internal Audits (OIA) on December 3, 2018. Responses to the second Information Documentation Request was submitted by Revenue Management to OIA on December 20, 2018 and then forwarded to the IRS.

For the minutes from meetings describing the FAP, the IRS was advised in a written document from Revenue Management that the minutes are available on the NYC Health + Hospitals website (https://www.nychealthandhospitals.org/public-meetings-notices/).

A copy of the Bad Debt policy was provided to the IRS on November 1, 2018 where the billing and collection policies are explained; however, Revenue Management does not have a written Billing and Collection Policy. Responses to the second Information Documentation Request was received from Revenue Management on December 20, 2018. They are currently working on a draft ‘Billing and Collection Policy’.

The FY16 Community Health Needs Assessment (CHNA) reports were coordinated by the Office of Internal Audits and mailed to the IRS on December 3, 2018.

B. OTHER AUDIT ACTIVITIES

a) Mayor's Office Communications

Periodically, the Office of Internal Audits receives status requests from the Audit Services function within the NYC Mayor's Office of Operations regarding audits being conducted by regulatory agencies of Health + Hospitals. OIA is responsible for regularly advising the individuals within Audit Services of the audits in progress, sending them draft/final reports and responses and inviting them to entrance and exit conferences.

A request of this nature was received and adequately responded to in January 2019.

b) Anonymous Letters

During Calendar Year 2018, 15 accusation letters were received by the Office of Internal Audits for their review. Most of the letters were found to be without merit or forwarded to other parties for review. Independent investigations were conducted of two anonymous letters received by the Office of the Chair. Internal Audits issued reports to the Chairman, President and Chief of Staff addressing the allegations within each letter.

c) Auxiliary Audits

These financial statement certifications are conducted by an outside CPA firm (BKD, previously known as Loeb & Troper). The objective of these audits is to enable the auditors to express an opinion on the financial statements and provide reasonable, not absolute assurance, that the financial statements taken as a whole are free from material misstatement.

Internal Audits responsibilities include:

- Meeting with BKD to develop the audit plan, issue notification letters to the Auxiliary representatives, and to assist the Auditors with any problems they may encounter.
- Reviewing the draft report which includes comparing the numbers to the prior year's audit, requesting documentation to support certain financial information and inquiring about questionable numbers.
- Reviewing the final report to ensure it compares favorably to the draft report and issuing to the appropriate individuals at the Auxiliaries and NYC Health + Hospitals.

21 of 22 final reports were issued in 2018. The only audit not completed was of NYC Health + Hospitals/Queens. This was due to the Auxiliary not providing timely financial records needed to conduct the audit.

d) *FOIL Request*

A request for documents under the Freedom of Information Law was forwarded to Internal Audits on January 17, 2019. The initial request was made by the New York Times. The following documents were requested:

1) The results of any audits of spending by Health + Hospitals that were performed by outside agencies or third parties since 2014;
2) The conclusions of any internal investigations conducted by Health + Hospitals related to spending by the agency.

Five final reports from the NYC and NYS Comptroller's Offices were sent to H+H's FOIL Office in response to the first request. Only two were considered to be about Health + Hospitals spending.

The second request was not applicable as there were no internal investigations conducted.

NYC
HEALTH+
HOSPITALS

AUDIT COMMITTEE OF THE NYC HEALTH + HOSPITALS BOARD OF DIRECTORS

<u>Audit Committee Meeting</u>

Corporate Compliance Report

February 14, 2019

AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
February 14, 2019 @ 10:00 AM

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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
February 14, 2019 @ 10:00 AM

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.

2) To ensure that NYC Health + Hospitals (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 December 1, 2018 through January 31, 2019

3) During the period December 1, 2018 through January 31, 2019, there were no excluded individuals or providers.

4) As previously reported, on July 31, 2018, the OCC learned that a human resources administrator at NYC Health + Hospitals/Kings ("Kings), who was provided to NYC Health + Hospitals through a staffing agency, was an excluded individual. She worked at Kings from April 2018 through the end of July 2018. The OCC investigated the possibility of an overpayment for this individual and reported an overpayment to the OMIG, and the possibility of an overpayment to National Government Services. It was ultimately determined that an overpayment amount of approximately $9,000 was owed to the Medicaid program. That amount was fully repaid on December 24, 2018.

[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.

Death Master File and National Plan and Provider Enumeration System Screening

5) 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.

6) No providers were identified on the DMF or NPPES during the period December 1, 2018 through January 31, 2019.

II. Privacy Incidents and Related Reports

Reported Privacy Incidents for the period of December 1, 2018 through January 31, 2019

7) During the period of December 1, 2018 through January 31, 2019, seventeen (17) privacy incidents were entered into the RADAR Incident Tracking System. Of the seventeen (17) incidents, eight (8) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures ("OPs"); six (6) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security OPs; and three (3) are still under investigation. Of the eight (8) incidents confirmed as violations, four (4) were determined to be breaches.

Breach Defined

8) A breach is an impermissible use, access, acquisition or disclosure (collectively referred to as "use and/or disclosure") under the HIPAA Privacy Rule that

[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)").

compromises the security and privacy of protected health information ("PHI") maintained by the System or one of its business associates.[5]

9) Pursuant to 45 CFR § 164.402(2), the unauthorized use and/or disclosure of PHI is presumed to be a breach unless the System can demonstrate, through a thorough, good faith risk assessment of key risk factors, that there is a low probability that the PHI has been compromised.[6]

Reported Breaches for the Period of December 1, 2018 through January 31, 2019

10) As stated above, there were four (4) reportable breaches between December 1, 2018 and January 31, 2019, which are summarized below.

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

Incident: This incident was brought to our attention on December 24, 2018, and occurred when a patient contacted the Bellevue Administrator on Duty ("AOD") alleging that staff in the Comprehensive Psychiatric Emergency Program ("CPEP") had inappropriately provided medical records to an Administration for Children's Services' ("ACS") worker who subsequently used those records in a child custody court hearing.

Breach Determination: The OCC determined that a breach did occur, and that records were provided to the ACS worker without patient authorization. The records included mental health visit information related to a recent patient encounter and a letter from CPEP administration noting follow-up appointments scheduled for the patient and a referral to outpatient Behavioral Health. A breach notification letter was sent to the patient on January 22, 2019.

Mitigation: OCC worked with the CPEP department administrators to determine which records were inappropriately disclosed. The staff involved in providing the records to the ACS worker was counseled and provided with targeted HIPAA remediation training, and administration distributed reminders regarding patient privacy to all staff within the department.

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

- **NYC Health + Hospitals/Kings ("Kings") – December 2018**

Incident: This incident was brought to the attention of the OCC on December 27, 2018, when a patient reported that a Kings' employee videotaped her and her mother (who was also a patient) on October 29, 2018, while they were in a waiting area at Kings. The employee then posted the video on Facebook.

Breach Determination: After an investigation, it was determined that the video was taken in the hospital by the employee; the patients' were identified in the video by name; and the information had been made available to thousands of people via Facebook. Breach notification will be sent to the affected individuals.

Mitigation: The employee involved was counseled on the HIPAA privacy rights of patients. Labor Relations plans formal disciplinary action against the employee and Kings' management would like to terminate the employee. Kings will also intensify HIPAA training for its staff.

- **NYC Health + Hospitals/Kings ("Kings") – December 2018**

Incident: This incident was discovered on August 30, 2017, and occurred between December 20, 2014, and March 26, 2018. It involved a Kings employee who was misappropriating patient information and selling it to third parties. During the pendency of a joint investigation conducted by the United States Federal Bureau of Investigation ("FBI") and the NYC Health + Hospitals' Inspector General ("IG"), a law enforcement hold prevented NYC Health + Hospitals from providing notice to the affected individuals. As a result of the joint FBI and IG investigation, it was determined that the PHI of 419 patients was improperly disclosed by the Kings employee. This employee was terminated on April 9, 2018, and is being criminally prosecuted in Federal district court. The PHI disclosed included patients' names and telephone numbers. To the OCC's knowledge, no other information was disclosed. Although this incident occurred several months ago, the law enforcement hold was only lifted in December 2018, after which the System could send breach notifications to the affected individuals.

Breach Determination: As the PHI was found to have been transferred outside of the system to unauthorized individuals, it was determined that the security of the information had been compromised. Breach notification is being sent to all affected individuals.

Mitigation: Kings has taken a number of steps in response to this incident: Kings fully cooperated with law enforcement in the investigation of this matter; terminated the employee responsible for the breach; and increased its security-awareness training so as to emphasize to workforce members their responsibility with respect to HIPAA Privacy and Security compliance. The System also engaged the services of a third-party risk management vendor, Kroll Information Assurance, LLC, to provide credit monitoring, identity theft consultation and restoration to affected individuals for one year.

- **NYC Health + Hospitals/At Home – January 2019**

Incident: This incident was brought to the OCC's attention on January 16, 2019, and involved a Health Home care coordinator who logged onto a non-secure web portal and shared PHI of a patient with the city's the Department of Homeless Services ("DHS"). Specifically, the care coordinator posted a complaint on DHS' web portal in an attempt to switch shelter accommodations for a patient, and in the process, shared the patient's PHI on the portal. The care coordinator had not been authorized to share that information, and had not informed her supervisor that she was making a complaint on the web portal. The patient information in the complaint included the patient's name, date of birth, and mental health and medical condition.

Breach Determination: Although the outreach specialist at DHS was informed not to disclose the patient information further, there existed a greater than low probability that the PHI had been compromised. Notification will be sent to the patient whose PHI was compromised.

Mitigation: The Health Home care coordinator will be retrained on HIPAA, the importance of maintaining the confidentiality of patient information, and the need to safeguard such information. Further disciplinary action may be taken against the care coordinator based on additional information.

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

11) There were no inquiries initiated by the OCR during the period December 1, 2018 through January 31, 2019.

III. Compliance Reports

Summary of Reports for the Period of December 1, 2018 through January 31, 2019

12) For the period December 1, 2018 through January 31, 2019, there were fifty-six (56) compliance reports, none of which were classified as Priority "A,"[7] fifteen (15) (27%) were classified as Priority "B," and forty-one (41) (73%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints.

13) Priority B Report of Note: The OCC received a complaint filed by an employee at Gouverneur, who alleged inappropriate and unprofessional behavior, up to and including fraud, by NYC Health + Hospitals leadership, including a lack of monitoring of document verification by the Office of Medical and Professional Affairs ("OMPA"), missing signatures, falsified information on credentialing documents, and an inappropriate use of signature stamps for document approvals. The employee also alleged that there was targeted harassment toward her by the OMPA, resulting in her transfer to a different position and location at Gouverneur. Following and investigation by the OCC, however, it was discovered that this employee had in fact knowingly submitted unverified and possibly incorrect credentialing information on her report to the OMPA, which detailed provider profile listings of the approval dates for the Gotham Health transitioned providers indicating that their credentialing files were verified as complete, when they were not. The employee admittedly altered the "Date" field in the electronic credentialing system (IntelliCred) so that it appeared that all of the required providers for that time period had been fully vetted. She further reported that not

[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.

only was the credentialing information in the electronic record incomplete, but in some cases inaccurate.

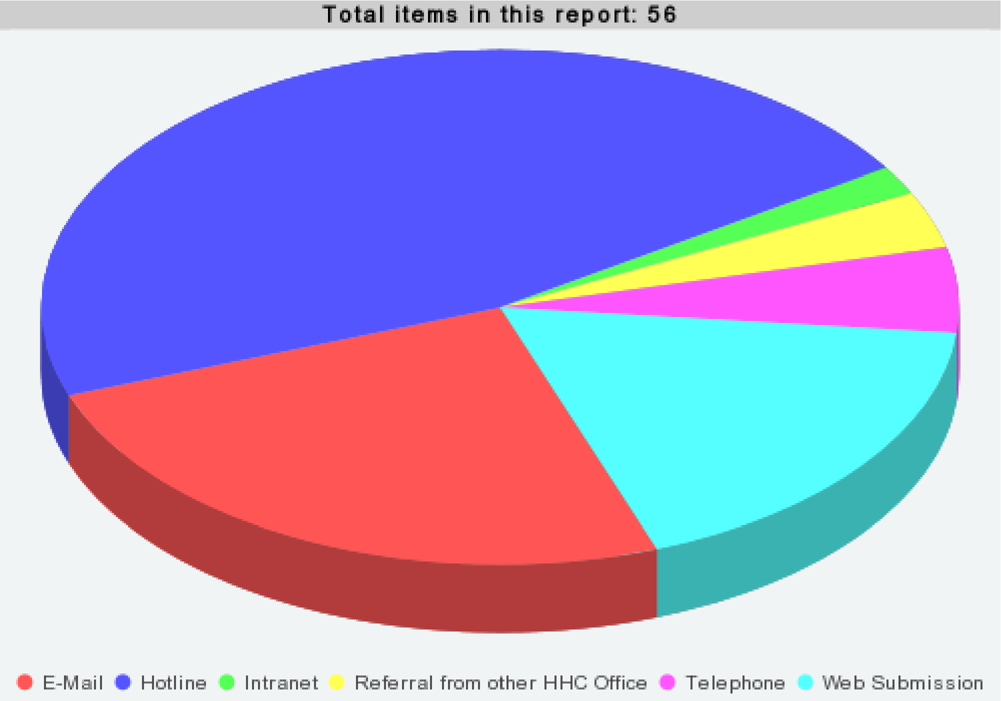
14) In addition, the employee reported that she completed certain training courses for a physician, which were required for the physician's credentialing. The OCC's investigation revealed that the physician's assistant instructed the employee to "handle" certain credentialing items, including one of the training courses, on behalf of the physician. The investigation also revealed that the employee obtained additional credentialing information on the physician's behalf.

15) Based on the findings of its investigation, the OCC recommended that the employee be suspended or terminated. The OCC submitted its findings and recommendation to Human Resources, and the employee was subsequently terminated.

a. PRIMARY ALLEGATION SOURCES

The fifty-six reports were received from the below-listed sources.

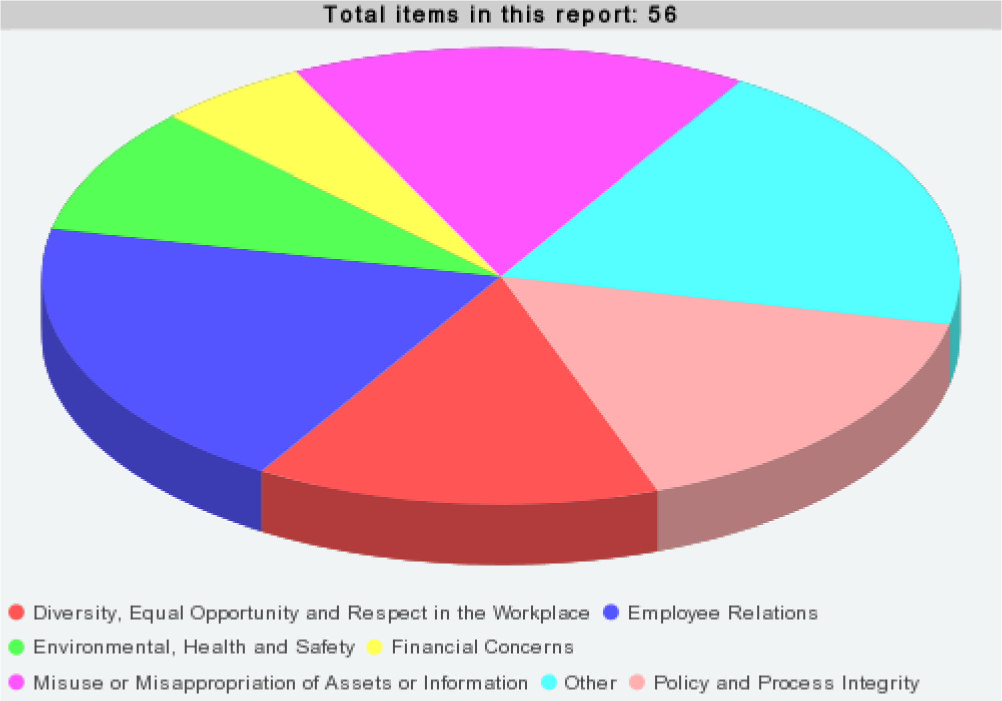
SOURCE - CHART DATA	
	Frequency (Percentage)
E-Mail	14.0 (25 %)
Hotline	26.0 (46.4 %)
Intranet	1.0 (1.8 %)
Referral from other HHC Office	2.0 (3.6 %)
Telephone	3.0 (5.4 %)
Web Submission	10.0 (17.9 %)
Totals	56.0 (100%)



b. PRIMARY ALLEGATION CLASS

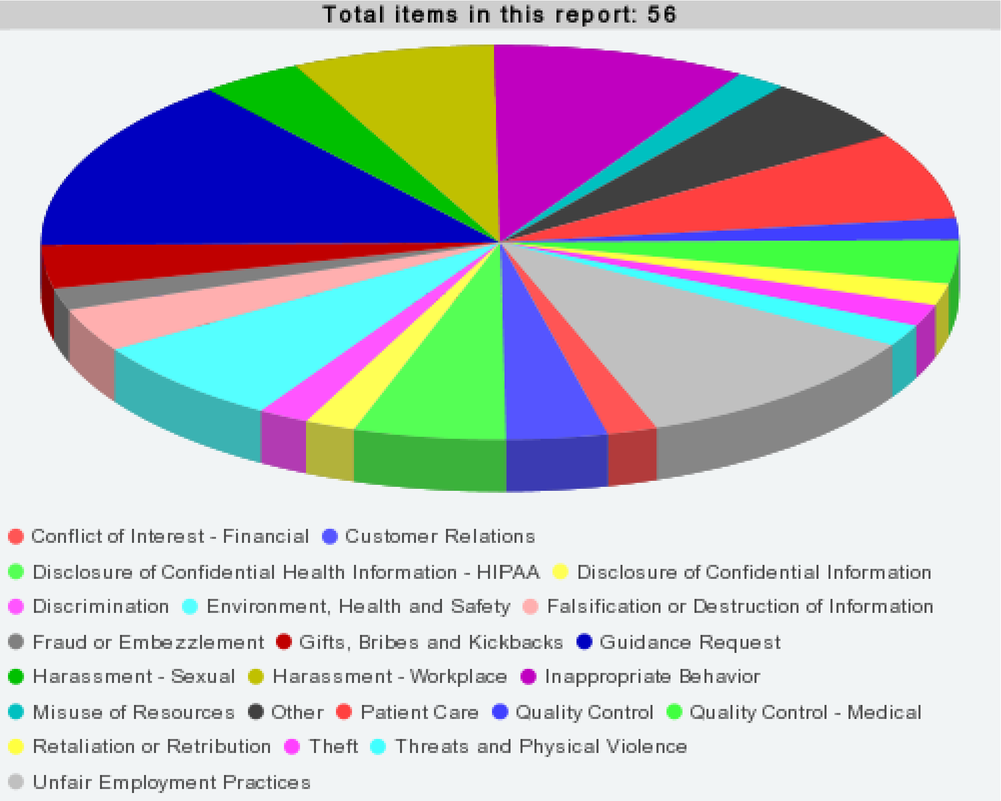
The class and nature of the reports filed were categorized as follows:

PRIMARY ALLEGATION CLASS - CHART DATA	
	Frequency (Percentage)
Diversity, Equal Opportunity and Respect in the Workplace	8.0 (14.3 %)
Employee Relations	11.0 (19.6 %)
Environmental, Health and Safety	5.0 (8.9 %)
Financial Concerns	3.0 (5.4 %)
Misuse or Misappropriation of Assets or Information	9.0 (16.1 %)
Other	11.0 (19.6 %)
Policy and Process Integrity	9.0 (16.1 %)
Totals	56.0 (100%)


Total items in this report: 56
● Diversity, Equal Opportunity and Respect in the Workplace
● Employee Relations
● Environmental, Health and Safety
● Financial Concerns
● Misuse or Misappropriation of Assets or Information
● Other
● Policy and Process Integrity

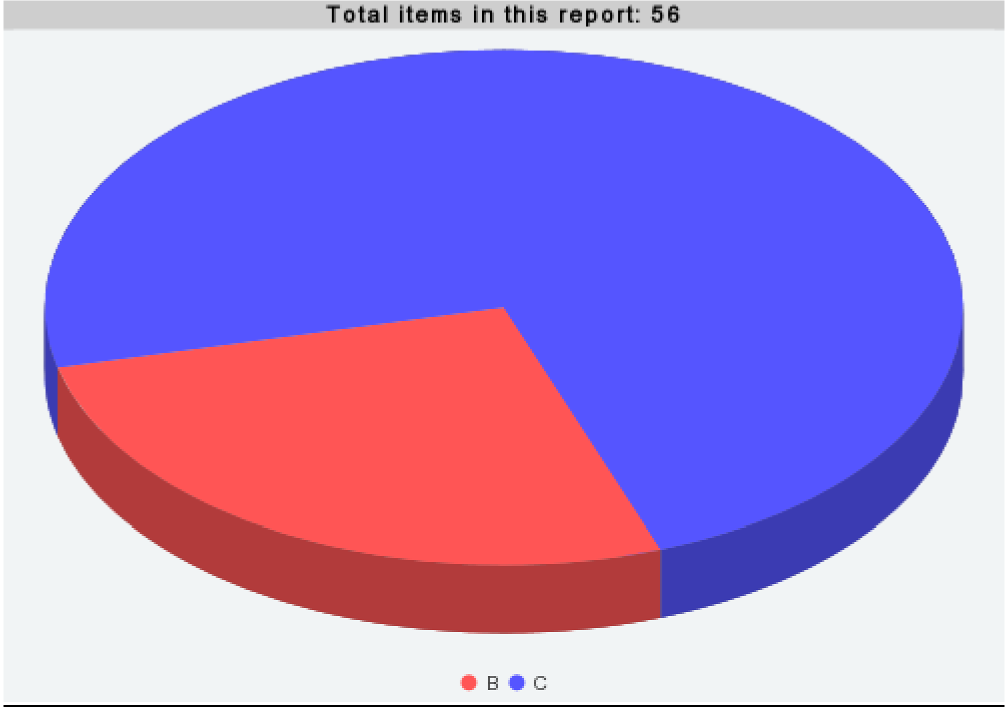
c. PRIMARY ALLEGATION TYPE

PRIMARY ALLEGATION TYPE - CHART DATA	
	Frequency (Percentage)
Conflict of Interest - Financial	1.0 (1.8 %)
Customer Relations	2.0 (3.6 %)
Disclosure of Confidential Health Information - HIPAA	3.0 (5.4 %)
Disclosure of Confidential Information	1.0 (1.8 %)
Discrimination	1.0 (1.8 %)
Environment, Health and Safety	4.0 (7.1 %)
Falsification or Destruction of Information	2.0 (3.6 %)
Fraud or Embezzlement	1.0 (1.8 %)
Gifts, Bribes and Kickbacks	2.0 (3.6 %)
Guidance Request	8.0 (14.3 %)
Harassment - Sexual	2.0 (3.6 %)
Harassment - Workplace	4.0 (7.1 %)
Inappropriate Behavior	5.0 (8.9 %)
Misuse of Resources	1.0 (1.8 %)
Other	3.0 (5.4 %)
Patient Care	4.0 (7.1 %)
Quality Control	1.0 (1.8 %)
Quality Control - Medical	2.0 (3.6 %)
Retaliation or Retribution	1.0 (1.8 %)
Theft	1.0 (1.8 %)
Threats and Physical Violence	1.0 (1.8 %)
Unfair Employment Practices	6.0 (10.7 %)
Totals	56.0 (100%)



d. PRIORITY CLASSIFICATION

PRIORITY - CHART DATA	
	Frequency (Percentage)
B	15.0 (26.8 %)
C	41.0 (73.2 %)
Totals	56.0 (100%)



IV. Status Update - HHC ACO, Inc.

16) 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" Accountable Care Organization ("ACO"), which includes Medicaid, commercial insurance, and Medicare Advantage. In December 2018, HHC ACO finally received a Certificate of Authority from DOH authorizing it to operate as an all payor ACO.

17) 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 set forth a number of proposed changes to the MSSP, including changes that encourage ACOs to take on greater risk. The final rule was issued on December 31, 2018.

18) Prior to issuing the final rule, CMS announced that ACOs may elect to extend their participation agreements for six months. CMS permitted this extension to allow

ACOs more time to implement two-sided risk arrangements. HHC ACO, therefore, elected to extend its participation agreement with CMS through June 30, 2019.

19) Currently, HHC ACO is applying to CMS for a contract to adopt the enhanced track of the MSSP, beginning July 1, 2019, which will involve potential shared losses, as well as shared savings. The shared savings, however, could potentially be as much as 75% of the savings to the Medicare program. Although the enhanced track provides for enhanced savings, it also carries the most risk – amounting to 40% to 75% of the losses to the Medicare program. The losses, however, are adjusted by HHC ACO's quality scores, and capped at 15% of the benchmark.

V. Aetna Desk Review

20) 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.

21) 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.

22) 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.

23) 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 conferred with the Office of Legal Affairs regarding the System's obligation to comply with this requirement, and responded that it continued to maintain its position that such requirement does not apply to the NYC Health + Hospitals.

24) On January 31, 2019, the OCC received another email from Aetna requesting that the OCC provide documentation to demonstrate the System's adherence to the CMS requirement related to retaining existing employee training records for a 10-year period. In addition, Aetna provided a random selection of five System employees with hire dates of 2009 and prior, which were identified from the System's original employee universe. Aetna requested that the OCC provide the necessary evidence demonstrating completion of these employees' Code of Conduct and Compliance training for the past ten years, by February 15, 2019.

VI. Records Management

Prior Situation

25) 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 an 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, and Enterprise Information Technology Services ("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.

26) Subsequently, 61,310 of the 621,000 boxes were 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 submitted a request for destruction approval for these boxes to the facilities' leadership, explaining the analysis and the methodology used to determine the need for destruction, along with the costs associated with storing such boxes.

27) In addition, 77,359 of the 621,000 boxes had an identified destruction date that was entered by a System workforce member. Destruction of these records were scheduled to follow the standard destruction process outlined in OP 120-19: *Corporate Records Management Program and Guidelines for Corporate Record Retention and Disposal.*

28) In total, therefore, approximately 138,700 boxes were identified to be slated for destruction, which would save the System approximately $74,898 monthly, and approximately $898,776 annually.

<u>Update on Document Destruction</u>

29) The following updates the status of the off-site paper records that are scheduled for destruction:

- Number of boxes from facilities with request to destroy waiting to be approved by facility leadership: 72,850 boxes (non-clinical records older than six years)
- Number of boxes from facilities with request to destroy approved by facility leadership: 74,462 boxes (records with the destruction date of December 31, 2017 or earlier)
- Number of boxes from Central Office Administration with destruction date older than year 2018 (no owner but destruction dates identified): 1,914 boxes
- Number of boxes from 1800 Park Avenue clinic: 121 boxes (past their retention period)
- Number of boxes from Central Office Claims and Litigation: 341 Boxes (past their retention period)
- Total: 149,688 boxes, at an annual savings of approximately $970,000.

Next Steps & Future State of Records

30) As discussed during the December 2018 Audit Committee meeting, the go-forward strategy to manage records more efficiently and in a cost-effective manner, is digitization of those records that have to be retained pursuant to the System's OP 120-19.

31) The NY State Archives, which provides guidelines for the retention schedules for public agencies, such as NYC Health + Hospitals, published guidance[8] in 2014 on imaging, including image resolution requirements for different types of documents, color and pixel depths, quality check methods and indexing procedures. The guidelines require a minimum of 300 Pixels Per Inch ("PPI") for most types of records. Over the years, however, the System has scanned its on-site records at a lower resolution than the required 300 PPI. Re-scanning these records to meet the 300 PPI requirement would be extremely cost-prohibitive. Also, given that the System's priority now is to implement digitization as a go-forward solution to the extent possible, expending resources toward this goal would be of the most benefit for its records management agenda.

32) Thus, for those documents scanned at the lower resolution, NYC Health + Hospitals needed to request a waiver from the NY State Archives of the 300 PPI resolution requirement and their approval to destroy all paper records that have been scanned at a lower resolution and thoroughly checked for quality issues.

33) Therefore, the RMO spoke with a representative of the NY State Archives to request such waiver and approval to destroy such paper records. The representative advised the RMO that, as long as the scanned records are operational and can be used for the System's business functions, and there is a documented memorandum in the System's policies and procedures manual that includes the System's current state of digitized records with a strategy to approach digitization per NY State Archives' guidelines, the System would be able to destroy records scanned at the lower resolution. The Office of Legal Affairs concurred with this approach, in addition to memorializing the phone conversation with and emails received from the NY State Archives. Accordingly, the RMO has documented such memorandum

[8] *See* Section 12: Imaging Resolution of the NY State Digital Imaging Guidelines 2014: available at http://www.archives.nysed.gov/common/archives/files/mr_erecords_imgguides.pdf

in OP 120-19, and the System will begin destroying previously scanned records after performing quality checks. This will prevent the increase in paper storage thus saving recurring costs to store off-site. The System's OP 120-19 will also be revised to reflect the imaging guidelines.

34) 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 ("ECM") application. Among other things, an ECM application 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. Currently, OnBase is being used as an ECM application for Epic to store scanned patient records.

35) On November 15, 2018, the RMO presented to the EITS Intake Meeting NYC Health + Hospitals' records digitization initiative as its future state for record retention. At the meeting, the EITS project management committee voted to advance the digitization initiative to the Health Information Technology ("HIT") Prioritization 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 Prioritization Committee meeting, the initiative will become an "IT Project" which will be tracked and assigned technology resources.

36) Accounts Payable was selected to be the first area to be digitized. Based on walkthroughs of the department, it was determined that there are approximately 680 boxes of documents that would need to be scanned, including vouchers, receipts, purchase orders, invoices etc. EITS is working on the system architecture to start digitizing the Accounts Payable records, including the determination and design of the system that will house the digital copies (OnBase ECM application), the methodology for indexing (keywords, meta data, destruction dates etc.), the ultimate application that will be used to retrieve the digital copies of the record archives (*e.g*., PeopleSoft, Financials, Accounts Payable Module), and the plan to digitize documents as they come into the department. Once the architecture is ready, the project will be presented at the HIT Prioritization Committee. Similar digitization projects are also being discussed with Human Resources and Payroll, and information gathering is in process.

37) NYC Health + Hospitals currently uses the vendor Caso for its scanning. Article XI, § 162 of the New York State Finance Law, which established the Preferred Source Program, requires government agencies, including public benefit corporations, to purchase certain services through the Preferred Provider Program. New York State Industries for the Disabled, Inc. (“NYSID”) is a facilitating agency for the Preferred Source Program, and NYSID requires agencies to use Caso for data imaging.