NYC HEALTH + HOSPITALS

AUDIT COMMITTEE
MEETING AGENDA

June 13, 2019

11:00 A.M.

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

CALL TO ORDER — Mr. José Pagán

- Adoption of Minutes April 9, 2019 — Mr. José Pagán

ACTION ITEMS

INFORMATION ITEMS

- Grant Thornton, LLP 2019 Audit Plan — Ms. Tami Radinsky, Partner
- Audits Update — Mr. Chris A. Telano
- Compliance Update — Ms. Catherine Patsos

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: April 9, 2019
TIME: 11:00 A.M.

COMMITTEE MEMBERS

Jose Pagán, PhD
Matthew Siegler, SVP (Representing Mitchell Katz, CEO in a voting capacity)
Scott French (Representing Helen Arteaga Landaverde, Chair in a voting capacity)

STAFF ATTENDEES

Andrea Cohen, General Counsel, Legal Affairs
Colicia Hercules, Chief of Staff, Chairman's Office
Sharon McPherson, Senior Secretary, Chairman's Office
John Ulberg, Chief Financial Officer
Jay Weinman, Corporate Comptroller
Catherine Patsos, Compliance Officer
Paul Albertson, Vice President, Supply Chain
Devon Wilson, Senior Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Jose Santiago, Controller, MetroPlus
Donnie Bell, Deputy Chief Medical Officer, H+H/Kings
Beverly P. Addai, Senior Associate Accountant, H+H/Metropolitan

AUDIT COMMITTEE MINUTES
APRIL 9, 2019

CALL TO ORDER

The meeting was called to order by Mr. José Pagán, Board Chair called the meeting to order at 10:55 A.M.

Mr. Pagán stated that Mr. Matt Siegler, Senior Vice President is representing Dr. Mitchell Katz in a voting capacity. Per Section 14 of the By-Laws: Committee Attendance states, "if any member of a standing or special committee of the Board will not be present at a scheduled committee meeting, the member may ask the Chair of the Board to request that another Board member, not a member of that committee, attend the scheduled meeting and be counted as a member for purposes of quorum and voting." Helen Arteaga Landaverde requested of the Board Chair that, Mr. Scott French, who is representing Mr. Steven Banks in a voting capacity, have her vote at this meeting.

Mr. Pagán asked for a motion to adopt the minutes of the Audit Committee meeting held on December 13, 2018 and February 14, 2019. A motion was made and seconded with all in favor to adopt the minutes.

Mr. Telano, Senior Assistant Vice President, Internal Audits presented his update. He stated that the NYC Health + Hospitals received a notification letter on August 30th by The Internal Revenue Services for Compliance with Federal Tax Requirements. Mr. Telano stated after being on-hold during the government shutdown, this audit re-started on January 28, 2019. Mr. Telano stated the objective of the audit was to ensure Health + Hospitals is compliant with federal tax requirements as an exempt organization.

Mr. Telano stated during the entrance conference, the IRS requested our Financial Assistance Plan (FAP) for each hospital facility. Mr. Telano stated this document must apply to all emergency and other medically necessary care provided by the hospital facility and includes: 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 and the measures taken to widely publicize the FAP within the community served by the hospital.

Mr. Telano stated, the Financial Assistance Plan (FAP) for each hospital facility was provided to the IRS on November 1, 2018 by Revenue Management. Mr. Telano stated, 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.

Mr. Telano stated the IRS also requested the minutes from meetings describing the FAP during FY16, the billing and collection policy and actions taken in the event of nonpayment of fees. As well as the

Mr. Telano stated that 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/).

Mr. Telano stated, the IRS also requested 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 benefits through clinical services.

Mr. Telano stated, 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.

Mr. Telano also stated that a copy of the Bad Debt policy was provided to the IRS on November 1, 2018. However, Revenue Management did not have a written Billing and Collection Policy as of that date and the responses to the second Information Documentation Request was received from Revenue Management on December 20, 2018.

Mr. Telano stated that on February 7, 2019 the written Billing and Collection Policy, which was updated for the current EPIC environment, was submitted to OIA and forwarded to the IRS the next day.

Mr. Telano stated we are in continuous communication with the IRS and that on March 12, 2019 NYC Health + Hospitals was advised that the review of the documentation submitted was not done because of the back log from the government shutdown. The status did not change as of March 26, 2019. The Auditor is hoping to start the review sometime next week. Mr. Telano stated the status of this audit is on going

Mr. Telano stated NYC H+H received an audit notification letter on March 21, 2019 from the NYC Comptroller's Office for the Children of Bellevue Auxiliary

Mr. Telano stated, the preliminary entrance conference with the Comptroller's office was held on April 4, 2019 and the status is pending.

Mr. Telano stated that the Audit Engagement Letter stated that the audit was of Children of Bellevue's (CoB) financial and operating practices. Mr. Telano noted that the twenty-two Auxiliaries that exist within the various facilities of NYC Health + Hospitals are separate 501c3 not-for-profit corporations whose primary function is to enhance the quality of patient care. They do this by receiving and administering funds received from fund raising activities, gifts, and donations and distributing those funds for activities or projects that enhance the quality of patient care and for selected amenities not otherwise available to patients.

Mr. Telano stated the audit objectives are to determine whether CoB: have adequate controls over and accurately reports its revenues and expenses; is complying with applicable rules, regulations, policies and procedures; have computerized systems controls to ascertain the integrity, validity and reliability of its data.

Mr. Telano noted that the most recent audited financial statements of CoB, for Calendar Year 2017, shows Cash and Investments totaling over $1.25 million.

Mr. Telano noted a report was received from the Office of Inspector General (IG) regarding their review of the Inventory Controls within the Facilities Management Department at NYC Health + Hospitals/ Queens.

Mr. Telano stated that the report noted, there were no policies or practices for maintaining inventory control; work orders were completed without the cost of materials indicated; annual inventory counts were not conducted; Valuable

power tools were not tagged and their usage was not monitored and that the area in which the inventory was held lacked cameras, Hospital Police presence or other security measures.

Mr. Telano stated that discussions were held with the CEO from Queens, the Corporate Vice President of Facilities and other interested parties regarding the report and determined that the deficiencies found by the IG existed at the other facilities in the System. Hence, the responses to the findings would be at the System-wide level instead of from one facility.

Mr. Telano stated the responses first addressed an incorrect comment made within the report. The IG stated that there was approximately $1.6 million in inventory purchased in fiscal years 2017 and 2018. However, their totals included various maintenance contracts (i.e. elevators) and service repair contracts. It was found that only $287,000 was spent for inventory in FY18 and a comparable amount was spent for 2017.

Mr. Pagán asked if there was going to be a follow-up.

Mr. Telano answered that once they receive our response, there will most likely be a follow-up. Mr. Telano stated, other responses to the findings were that NYC Health + Hospitals will develop Procedures once inventory controls, such as a baseline and par levels, are established, that NYC Health + Hospitals will work toward achieving the recommendations to include the material cost option for all work orders and requiring supervisory approval before closing them. Resources need to be identified to ensure adherence before this is implemented; that we are working towards a computerized inventory system that parallels the current system used for medical supplies. Annual inventories can then be performed in a digital fashion with increased accuracy. We will begin a review regarding a scanning program for expensive tools used by trades' personnel. A policy will be written requiring a reporting of missing tools and that Cameras and card swipes will be installed at NYC Health + Hospitals/Queens within the next six months in all areas that are designated for storage and/or equipment.

Mr. Telano stated that since the last Committee meeting, the Office of Internal Audits was forwarded two anonymous letters received by the President's Office. The first letter included complaints about the management within the Medical Records Department at NYC Health + Hospitals/Kings. Further inquiry revealed that this was not the first letter received regarding this matter. As a result, the IG had already begun an investigation; OIA would then defer to them to avoid duplication of efforts.

The second letter involved the purchasing habits of the Facilities Manager at NYC Health + Hospitals/Gouverneur. Discussions were held with Corporate Facilities Management to obtain some background information. An evaluation of the purchasing history within this department is currently underway. This investigation is on-going.

Ms. Catherine Patsos, Chief Corporate Compliance Officer provided and update - she stated that during the period of February 1, 2019 through March 31, 2019, there was one disciplined individual and one sanctioned vendor identified on the Exclusion and Sanction Screening Report.

Ms. Patsos stated that on February 28, 2019, the OCC was notified by its vendor that a registered nurse within NYC Health + Hospitals/At Home had a two-month actual suspension, twenty-two-month stayed suspension, and twenty-four-month probation on her license. Ms. Patsos stated the OCC is looking into whether there could be an overpayment related to her suspensions and probation. Ms. Patsos noted, on March 22, 2019, however, the employee was terminated due to inappropriate behavior and interactions with shelter administrators.

Ms. Patsos stated that on March 13, 2019, the OCC was informed that a vendor possessed a sanction through the Environmental Protection Agency due to a violation of the Clear Water Act. The OCC is in the process of determining whether this sanction would cause an overpayment issue.

Ms. Patsos stated that no providers were identified on the Death Master File (DMF) or National Plan and Provider Enumeration System (NPPES) screening during the period February 1, 2019 through March 31, 2019.

I. Privacy Incidents and Related Reports

Ms. Patsos stated that during the period of February 1, 2019 through March 31, 2019, sixteen (16) incidents were entered in the RADAR Incident Tracking System and off the sixteen (16) incidents, nine (9) were found after investigation to be violations of NYC Health + Hospitals' HIPAA Privacy and Security Operating Procedures; six (6) were found not to be a violation of NYC Health + Hospitals' HIPAA Privacy and Security Operating Procedures; and one (1) is still under investigation. Ms. Patsos noted that of the nine (9) incidents confirmed as violations, none were determined to be a HIPAA breach.

Update on Incidents Previously Under Investigation:

Ms. Patsos stated two (2) previously discovered incidents that had been under investigation, were found to be breaches. One was with NYC Health + Hospitals/McKinney ("McKinney") in November 2018. Ms. Patsos stated that on November 30, 2018, the OCC was informed by the Deputy Inspector General of NYC Health + Hospitals Office of the Inspector General ("IG") that the PHI of 260 McKinney residents was mistakenly released by NYC Health + Hospitals to two potential vendors of NYC Health + Hospitals. Ms. Patsos stated the information was inadvertently released in September 2016 by Post-Acute Care leadership to Omni Care Inc. and Pharm Script, LLC to calculate potential savings that could result from outsourcing NYC Health + Hospitals' post-acute pharmacy services. Ms. Patsos noted the PHI that was released included patients' names, insurance, and medications.

Ms. Patsos stated although the information disclosed was limited in nature, the inability to mitigate the risk to the PHI and the length of time since the occurrence contributed to the determination that there existed a greater than low probability that the PHI may have been compromised. Therefore, the OCC sent breach notifications to the affected individuals.

Ms. Patsos stated the OCC reviewed this incident with the Post-Acute Care leadership, and reminded them of the need to safeguard PHI.

Ms. Patsos stated that the other incident was with NYC Health + Hospitals/Lincoln ("Lincoln") in November 2018. Ms. Patsos stated that this incident occurred on November 2, 2018, when a social worker at Lincoln mistakenly faxed referral documents containing PHI to the wrong home care agency. Ms. Patsos noted the PHI disclosed included the patient's name, date of birth, home address, medical history, complaints, diagnoses, treatment, and insurance information.

Ms. Patsos stated even though the entity that received the PHI is a home care agency, and is therefore required to protect the privacy of any PHI it receives, the agency would not give the OCC written assurance that the PHI had been properly disposed of and had not been used or further disclosed for any purpose. Ms. Patsos stated the OCC,

therefore, determined that there was more than a low probability that the security of the information had been compromised, and sent a breach notification to the affected individual.

Ms. Patsos stated that in response to this incident, the social worker involved was counseled and reeducated on HIPAA privacy requirements, and a refresher training was provided to the entire Lincoln Social Work Department

Ms. Patsos stated there were no inquiries initiated by the office for Civil Rights (OCR) during the period February 1, 2019 through March 31, 2019 regarding privacy incidents.

Ms. Patsos did stated although there were no such inquiries, on February 22, 2019, the OCR met with OCC and Enterprise Information Technology Services ("EITS") leadership, along with in house and outside counsel, to discuss NYC Health + Hospitals' compliance with HIPAA, including the System's safeguards of its ePHI. During this meeting, the OCC and EITS explained to the OCR that the System has many controls in place to safeguard its ePHI, in compliance with HIPAA requirements. The OCR requested that the System document such current controls, as well as additional planned controls, in a letter to the OCR. Ms. Patsos stated the OCC submitted such letter to the OCR on March 4, 2019, with follow-up documentation on March 18, 2019. Ms. Patsos noted that the OCC will continue providing the OCR with additional documentation of its compliance with HIPAA as outlined in the letter.

Ms. Patsos stated for the period February 1, 2019 through March 31, 2019, there were sixty-one (61) compliance reports, none of which were classified as Priority "A," twenty (20) (33%) were classified as Priority "B," and forty-one (41) (67%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints.

Ms. Patsos stated on March 18, 2019, the Director of Human Resources at NYC Health + Hospitals/Coney ("Coney") forwarded an email to the OCC which contained a statement from a physician assistant in Occupational Health Service ("OHS") that a laboratory employee from Coney was seen in OHS for her annual health assessment in November 2018. During that assessment, the employee asked the physician assistant to order additional blood work pertaining to iron deficiency; however, the physician assistant advised the employee that this was not permissible. Ms. Patsos stated that according to the physician assistant, on February 13, 2019, she received laboratory work results for six tests that the employee had previously requested. The physician assistant reported that the employee had admitted that she ordered the tests on herself and that "everybody does that."

Ms. Patsos noted that an investigation of this matter is underway, and NYC Health + Hospitals laboratory leadership is aware of and will assist with the investigation. In the meantime, the Medical Director of the laboratory has begun retraining staff on who is permitted to order tests.

Ms. Patsos stated The New York State Department of Health ("DOH") Security and Privacy Bureau ("Bureau") conducted a review of NYC Health + Hospitals/OneCity Health's ("OneCity Health") Performing Provider System ("PPS'") System Security Plan Controls Attestation Form for OneCity Health's internally hosted environment, and, on March 6, 2019, determined that it met the Bureau's criteria.

Ms. Patsos stated as a result, OneCity will be able to derive and share insight from sensitive DOH data with its Partners to support better outcomes for NYC Health + Hospitals and other OneCity Health Partners' patients. This

includes individual patient lists prioritizing care gaps to close, and summary analyses highlighting programmatic opportunities.

Ms. Patsos stated OneCity Health, as a PPS Lead in the DSRIP Program, it is responsible for taking "reasonable steps to ensure that Medicaid funds distributed as part of the DSRIP program are not connected with fraud, waste, and abuse. It is reasonable for a PPS Lead to consider its network performing providers' program integrity systems when dedicating resources and developing the PPS Lead's systems. To satisfy its compliance obligations, and to fulfill the requirements of the OMIG DSRIP compliance guidance, OneCity Health developed a compliance Attestation form, which is designed to assess its Partners' compliance with the program requirements.

OneCity Health Partners must certify annually to OneCity Health that they have met their DSRIP compliance training obligations and certain other compliance-related obligations.

Ms. Patsos stated, accordingly, last week, OneCity Health distributed a Memorandum from the OCC to OneCity Health Partners with a link to a *Compliance Attestation of OneCity Health Partners* ("Attestation"). The Attestation, which provides OneCity Health and the OCC with a critical snapshot of the compliance foundation of its DSRIP Partners, must be completed by all OneCity Health Partners and returned to the OCC by close of business April 30, 2019.

Ms. Patsos stated HHC ACO, Inc. ("HHC ACO") is in the process of submitting its application to renew its contract with CMS for the 2019-2024 agreement period. HHC ACO is applying to participate in the Enhanced track of the Medicare Shared Savings Program ("MSSP"), beginning July 1, 2019. The Enhanced track is a two-sided track, which will involve shared savings as well as potential shared losses. The shared savings could be as much as 75% of the savings to the Medicare program, adjusted by HHC ACO's quality score, and capped at 20% of total benchmark expenditure. Although the Enhanced track provides for the most allowed shared savings, it also carries the most risk – amounting to 40% to 75% of the losses to the Medicare program. The losses, however, are also adjusted by HHC ACO's quality scores, and capped at 15% of the total benchmark expenditure imposed by CMS.

Ms. Patsos noted the final submission date for the round of requested documentation to CMS for this agreement is May 2, 2019.

Ms. Patsos stated to ensure the System's compliance with the requirements of HIPAA and HIPAA regulations, the System had previously engaged a third party vendor to conduct HIPAA Risk Analyses and Security Assessments. The previous vendor's contract ended in August 2018, after which the OCC and the Information Security Risk Management ("ISRM") team of EITS issued a Request for Proposals ("RFP") to solicit proposals from vendors for the next round of HIPAA Risk Analyses and Security Assessments.

Ms. Patsos noted the Evaluation Committee for the RFP, which was comprised of individuals from the OCC and ISRM, received proposals from ten vendors, and selected four of them to provide presentations on their proposals. Of those four vendors, Coalfire Systems, Inc. ("Coalfire") received the highest score from the Evaluation Committee by a large margin, and its proposal was the one most closely aligned with the objectives of the RFP.

Ms. Patsos noted that Coalfire's initial cost proposal for a three-year contract was more than $7 million above the RFP budgeted expense; however, they were able to provide the OCC and ISRM leadership with five proposed options at significantly reduced expense. Ms. Patsos stated that of the five options, the one that most closely aligns with the

objectives of the RFP, and produces the minimal amount of risk of non-compliance with HIPAA requirements, is approximately $900,000 more that the budgeted expense for the three-year contract.

Ms. Patsos stated that he OCC outlined the budget difference to the System's Chief Information Officer ("CIO") and the rationale for choosing Coalfire over the next highest scoring vendor, and requested additional funding from EITS to cover the difference. Such funding was granted. The Evaluation Committee chose Coalfire to conduct the System's HIPAA Risk Analyses and Security Assessments for the next three calendar years. A two-day kick-off meeting with members of the OCC and ISRM in March, and work is underway for the 2019 Risk Analysis and Security Assessment.

Ms. Patsos stated 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. Ms. Patsos stated 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.

Ms. Patsos noted on April 30, 2018, the OCC received Aetna's Compliance Program Elements Audit Report (the "Audit Report"), which included Aetna's 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.

Ms. Patsos noted 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.

Ms. Patsos noted 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 NYC Health + Hospitals.

Ms. Patsos also noted 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 evidence demonstrating completion of these employees' Code of Conduct and Compliance training within the past ten years, by February 15, 2019. The OCC provided information to Aetna on February 15, 2019, and is waiting for their response.

Mr. Pagán proposed a motion to convene an executive session because the matters to be discussed involve confidential and privileged information and some information may relate to proposed or actual litigation. Mr. Pagán asked May I have a motion? Second? All in favor.

The motion to convene in executive session was unanimously approved by all. The Committee then convened in Executive Session

Open Session: There being no other business the meeting was adjourned at 11:46 A.M.

Presentation to the Audit Committee of The New York City Health + Hospitals Corporation

for the year ending June 30, 2019

June 13, 2019

Responsibilities

Our Responsibilities

We are responsible for:

- Performing the following audits of financial statements as prepared by management, with your oversight, conducted under US Generally Accepted Auditing Standards (GAAS) and, where applicable, under *Government Auditing Standards:*
  - New York City Health + Hospitals Corporation ("NYC Health + Hospitals") for the fiscal year ending June 30, 2019
  - HHC Accountable Care Organization Inc. annual financial statements for the fiscal year ending June 30, 2019
  - Metro Plus Health Plan's annual statutory financial statements for the fiscal year ending December 31, 2019
  - HHC Insurance Company's annual statutory financial statements for the fiscal year ending December 31, 2019
- Forming and expressing an opinion about whether the financial statements are presented fairly, in all material respects in accordance with US GAAP
- Reading other information and considering whether it is materially consistent with the financial statements
- Performing the following audits, as applicable, of cost reports for the year ending June 30, 2019 and issuance of certifications and attestation reports:
  - Annual Reports of Ambulatory Health Care Facilities (AHCF-1)
  - Annual Reports of Residential Health Care Facilities (RHCF-4)
- Communicating fraud involving management
- Communicating specific matters to you on a timely basis

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

Those Charged with Governance and Management Responsibilities

Those Charged with Governance

Those charged with governance are responsible for:

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

Management

Management is responsible for:

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

Views of those charged with governance

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

Audit Timing & Scope

Audit Timeline

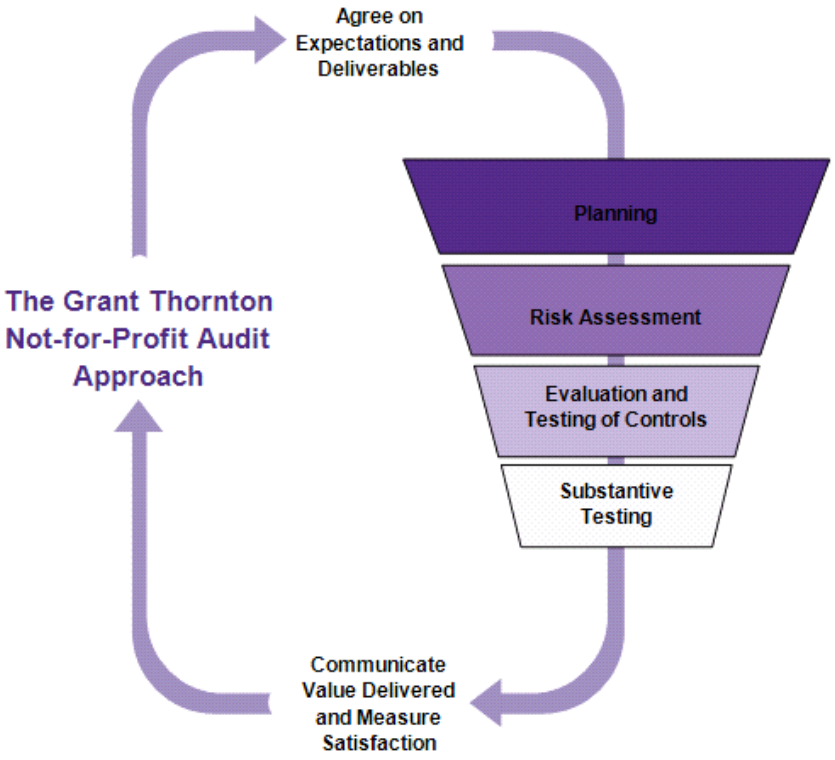
May - June 2019	**Client acceptance**	• Client acceptance • Issue engagement letter • Conduct internal client service planning meeting, including coordination with audit support teams such as IT and tax
May – June 2019	**Planning**	• Meet with management to confirm expectations and discuss business risks • Discuss scope of work and timetable • Identify current-year audit issues and discuss recently issued accounting pronouncements of relevance • Initial Audit Committee communications
June 2019	**Preliminary risk assessment procedures**	• Develop audit plan that addresses risk areas • Update understanding of internal control environment • Coordinate planning with management and develop work calendar
June – July 2019	**Interim fieldwork**	• Perform walk-throughs of business processes and controls • Perform control testing over healthcare revenue cycle • Perform selective substantive testing on interim balances
July – September 2019	**Final fieldwork**	• Perform final phase of audit and year-end fieldwork procedures • Meet with management to discuss results, draft financial statements and other required communications • Review final “draft” reports and other deliverables
October 2019	**Deliverables**	• Present draft reports and audit results to the Audit Committee and management • Issue final audit reports and other deliverables
December 2019	**Deliverables**	• Present final management letter to the Audit Committee

Audit Timeline (continued)

December 2019 - January 2020	**MetroPlus Health Plan**	• Perform walk-throughs of business processes and controls • Perform control testing over significant business processes • Perform selective substantive testing on interim balances
February 2020 – March 2020	**MetroPlus Health Plan**	• Perform final phase audit and year-end fieldwork procedures • Meet with management to discuss results, draft financial statements and other required communications • Issue the final audit report and other deliverables
April 2020 – August 2020	**Cost Report Certification and HHC Insurance Company**	• Perform applicable audit procedures and issue auditor's reports on cost reports for the skilled nursing facilities (RHCF-4) and diagnostic and treatment centers (AHCF) • Perform HHC Insurance Company audit and issuance of audit report
Timing to be determined	**HHC ACO, Inc.**	• Perform HHC ACO, Inc. audit and issuance of audit report (2018 and 2019)

Our Audit Approach

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



Significant Risks and other areas of focus

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

Areas of focus	Procedures
Patient accounts receivable, related contractual and uncollectable allowances and net patient service revenue	• Review account reconciliations including completeness and accuracy testing of the aged patient trial balances • Perform analytical procedures over key indicators such as days in accounts receivable, account write offs and aging of balances • Perform detailed account balance testing • Perform cut-off testing • Review management's methodology for estimating allowances • Perform medical record testing for existence (no confirmation procedures) and detail test of subsequent cash receipts • Perform a hindsight analysis of the prior year accounts receivable balance by reviewing cash collections on prior year balances • Perform cash to revenue proof to assist in the validation of the revenue balance
Estimated settlements due to third-party payers and net patient service revenue	• Review account reconciliations and roll-forwards and agree significant reconciling items to supporting schedules and documentation. • Perform detailed account balance testing • Review management's methodology for estimating amounts • Review the financial statement presentation and disclosures

Significant Risks and other areas of focus (continued)

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

Areas of focus	Procedures
Accounts Payable and Accrued liabilities, including malpractice reserves and contingencies	• Perform detail testing of management's calculations, including underlying inputs and data provided to specialists used in actuarial calculations for medical malpractice, workers compensation, pension and self-insurance health liabilities • Obtain and review outside actuarial reports used to determine pension and malpractice liabilities • Assess for reasonableness the assumptions used in developing estimates • Perform a search for unrecorded liabilities • Test the completeness and accuracy of accounts payable aged trial balance • Review payroll accruals for reasonableness

Significant Risks and other areas of focus (continued)

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

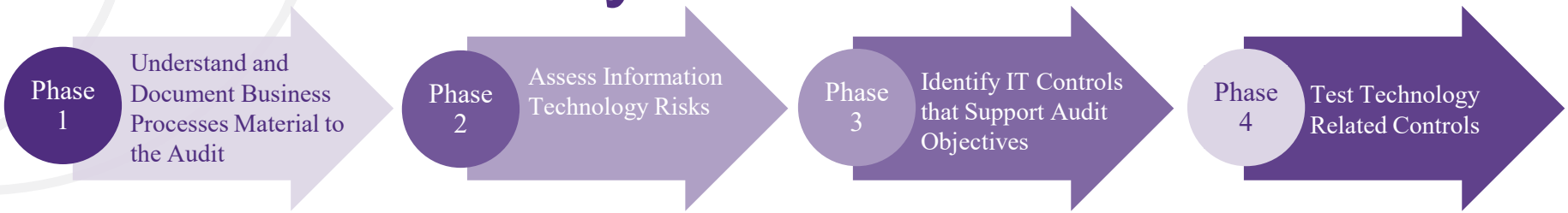
Areas of focus	Planned procedures
Accounting Estimates	The preparation of NYC Health + Hospital's financial statements requires management to make multiple estimates and assumptions that affect the reported amounts of assets and liabilities as well as the amounts presented in certain required disclosures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

Significant Risks and other areas of focus (continued)

Other Areas of Audit Focus

- Perform substantive testing on key account balances as of June 30, 2019, as follows:
  - Confirmation of cash and cash equivalents.
  - Test significant fixed asset additions and disposals, as applicable.
  - Test deferred revenue, as applicable.
  - Obtain debt rollforward and test payments throughout the year and compliance with debt covenants
  - Review and testing the completeness of accounts payable and accrued liabilities.
  - Perform an analytical review of revenues and expenses.
  - Identify and test non-routine transactions to ensure appropriate accounting treatment.
  - Independently confirm with internal and external legal counsel the potential exposure associated with outstanding claims, as applicable. Identify contingent liabilities or assets requiring accounting treatment or footnote disclosure.
  - Perform fraud procedures
    - Journal entry testing
    - Review inter-company accounts
    - Vendor testing

Information Systems Review



Our approach to testing **NYC Health + Hospitals'** information technology systems is detailed as follows:

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

Our engagement team will:

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

Phase 2: Assess information technology risks

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

Phase 3: Identify information technology controls that support audit objectives

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

Phase 4: Test technology related controls

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

Other Matters

Required Communication with the Audit Committee

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

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

Commitment to Promote Ethical and Professional Excellence

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

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

The EthicsPoint URL link

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

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

Our Values are CLEARR

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

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

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

Technical Updates - GASB

Selected pronouncements effective for the year ending June 30, 2019 or subsequent periods - GASB

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Title	Effective fiscal year ending
GASB 84- *Fiduciary Activities*	June 30, 2020*
GASB 87- *Leases*	June 30, 2021
GASB 88- *Certain Disclosures Related to Debt, including Direct Borrowing and Direct Placements*	June 30, 2019*
GASB 89- *Accounting for Interest Cost Incurred before the end of a Construction Period*	June 30, 2021
GASB 90 – *Majority Equity Interests – an amendment of GASB Statements No. 14 and No. 61*	June 30, 2020*
GASB 91 – *Conduit Debt Obligations*	June 30, 2022

*NYC H+H is early adopting GASB 84 and GASB 90 for June 30, 2019, and is required to adopt GASB 88 for June 30, 2019

GASB Statement 84, *Fiduciary Activities*

Summary	Potential impact
• Guidance addresses the following: - The categorization of fiduciary activities for financial reporting - How fiduciary activities are to be reported - When liabilities to beneficiaries must be disclosed • Types of fiduciary funds that must be reported include the following: - Pension (and other employee benefit) trust funds - Investment trust funds - Private-purpose trust funds - Custodial funds • A government controls the assets of an activity if it holds the assets or "has the ability to direct the use, exchange or employment of the assets in a manner that provides benefits to the specified or intended recipients" • Fiduciary activities must be disclosed in the basic financial statements of the government entity and a statement of fiduciary net position and changes in fiduciary net position should be presented (unless the period of custody is less than three months). • Effective for periods beginning after December 15, 2018, with early adoption encouraged.	Organizations often will agree to act as a fiduciary for certain third party entities that might be somehow affiliated to the organization. Under this new requirement, the Organization must report the fiduciary activity on its financial statements, where it may not have done so in the past. Management should identify which fiduciary activities it is engaged in to inventory the relationships which may need to be reported. Management may want to consider changing the terms of the relationships such that they are not subject to reporting on the financial statements of the Organization when the requirement becomes effective.

GASB Statement 87, *Leases*

Summary

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

GASB Statement 87, *Leases* (continued)

Summary, continued

- For Lessors:
  - Record a lease receivable and a deferred inflow of resources equal to the present value of future lease payments (which should generally equal the amount recorded as a liability by the lessee), and also continue to report the leased asset
  - The receivable will be reduce as cash is received, the asset will be depreciated (generally) and the deferred inflow will be recognized over the lease term
  - Disclosures regarding matters such as general description of leasing arrangements, total amount of inflows of resources, and those related to variable payments, residual guarantees, etc., and the existence, terms and conditions of options by the lessee to terminate the lease or abate payments in certain circumstances, among other disclosures
- Effective for periods beginning after December 15, 2019, with early adoption encouraged. Existing leases will be adjusted based on the remaining lease payments as of the beginning of the period of adoption or beginning of any earlier periods restated (for example, for June 30 year ends, adoption is June 30, 2021 so the beginning period is July 1, 2020).

Potential Impact

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

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

Summary	Potential impact

• Improves consistency of information presented in the footnotes with respect to long-term debt, and to distinguish it from other long-term liabilities in applying disclosure requirements.
• New guidance defines debt as "a liability that arises from a contractual obligation to pay cash (or other assets that may be used in lieu of payment of cash) in one or more payments to settle an amount that is fixed at the date the contractual obligation is established".
• In addition to the existing debt disclosures, organizations should disclose the following about all types of debt:
  • Amount of unused lines of credit
  • Assets pledged as collateral for debt
  • Terms specified in debt agreements related to significant events of default or termination events with finance-related consequences, as well as any subjective acceleration clauses
• Direct borrowings and direct placements of debt should be distinguishable from other types of debt for all disclosures.
• Effective for periods beginning after June 15, 2018. Changes to adopt this standard should be applied to all periods presented within the footnotes.
	Depending on the amount of information currently disclosed as it relates to debt, organizations may find themselves having to augment existing footnotes to comply with the standard, specifically as it relates to direct borrowings, lines of credit, and other debt instruments.
	
	HHC is evaluating this pronouncement for compliance with the provisions of this new standard.

GASB Statement 89, *Accounting for Interest Cost Incurred before the end of a Construction Period*

Summary	Potential impact

• This Statement improves financial reporting by providing users with more relevant information about capital assets and the cost of borrowing, and enhancing comparability of information for both governmental activities and business-type activities.
• Financial statements prepared using the economic resources measurement focus:
  • Interest cost should be recognized as an expense in the period incurred.
• Financial statements prepared using the current financial resources measurement focus:
  • Interest cost should be recognized as an expenditure consistent with governmental fund accounting principles.
• Effective for periods beginning after December 15, 2019, with early adoption encouraged. Changes to adopt this standard should be applied prospectively at adoption.
	Organizations may have varying amounts of interest incurred during periods of significant construction. With the implementation of this new guidance, complex calculations of interest to be capitalized will no longer be required, thus simplifying accounting requirements. The new accounting accelerates the expense impact for the construction period, which should be considered when preparing budgets for future periods.
	
	HHC is preparing for this new standard and will include the impact of this new standard in operating results for FY 2020.

GASB Statement 90, *Majority Equity Interests – an amendment of GASB Statements No. 14 and No. 61*

Summary	Potential impact

• Improves consistency and comparability of reporting a government's major equity interests in legally separate organizations.
• Defines an equity interest as a financial interest in a legally separate organization evidenced by the ownership of shares of the organization's stock or by otherwise having an explicit, measureable right to the net resources of the organization, usually based on an investment of financial or capital resources by the government.
  • If the equity interest holding meets the definition of an investment (GASB 72), the equity interest should be reported as an investment and measured using the equity method.
  • If the equity interest is held by a special-purpose government engaged only in fiduciary activities, a fiduciary fund, or an endowment or permanent fund, the equity interest should be measured at fair value
  • If the equity interest holding does not meet the definition of an investment, the legally separate organization should be reported as a component unit of the government.
  • If the legally separate organization is reported as a discretely-presented component unit, the equity interest should also be reported as an asset of the government (or fund) that holds the equity interest, measured using the equity method.
• Effective for periods beginning after December 15, 2018, with early adoption encouraged. Changes to adopt this standard should be applied retroactively, with certain exceptions.
	Organizations should inventory financial interests in legally separate organizations and evaluate whether such equity interests meet the definition of an investment. Depending on the nature of the equity interest and the intent for holding such interests, Organizations may find themselves reclassifying holdings between presentation as investments and component units.

GASB Statement 91, *Conduit Debt Obligations*

Summary	Potential impact

• Provides a single method of reporting conduit debt obligations by issuers and eliminate diversity in practice associated with (1) commitments extended by issuers, (2) arrangements associated with conduit debt obligations, and (3) related note disclosures
• Achieves objectives by:
  • Clarifying the existing definition of a conduit debt obligation
  • Establishing that a conduit debt obligation is not a liability of the issuer
  • Establishing standards for accounting and financial reporting of additional commitments and voluntary commitments extended by issuers and arrangements associated with conduit debt obligations
  • Improving required note disclosures
• Effective for periods beginning after December 15, 2020, with early adoption encouraged.
	For Organizations with conduit debt obligations reporting and disclosures of the debt obligations and related commitments could be impacted to apply uniform definition and reporting of those obligations and commitments.

GASB projects

Project	Timing
Financial Reporting Model- Reexamination of Statements 34, 35, 37, 41 and 46, and Interpretation 6	Preliminary Views comment period ended February 2019, planned issuance of final standard in 2022.
Revenue and expense recognition	Preliminary Views expected in May 2020 (currently in redeliberations)
Recognition (conceptual framework)	Preliminary Views comment period ended February 2019, planned issuance of final Concepts Statement in 2022.
Conduit Debt- Reexamination of Interpretation 2	Final statement expected May 2019
Deferred Compensation Plans – Reexamination of Statement 32	Deliberations scheduled to begin April 2019, Exposure Draft expected June 2019
Public-private partnerships, including reexamination of Statement 60	Exposure Draft expected June 2019
Implementation Guide- GASB 84 (Fiduciary Activities)	Final Implementation Guide expected May 2019
Implementation Guide- GASB 87 (Leases)	Final Implementation Guide expected June 2019

GASB major project – Financial Reporting Model

Summary

- GASB is revisiting its reporting model established in GASB 34 and 35, as well as other GASB standards, following the FASB project to revisit the reporting model of NFP entities.
- Although there is general consensus that most of the components of the financial reporting model are effective, the Board determined that there is a need to update guidance related to several categories, focusing on the following:
  - MD&A
  - Government-wide financial statements
  - Major funds
  - Governmental fund financial statements
  - Proprietary fund and business-type activity financial statements
  - Fiduciary fund financial statements
  - Budgetary comparisons
- Preliminary Views of note:
  - Definition of non-operating activities includes i) subsidies received and provided, ii) revenues and expenses of financing, iii) resources from the disposal of capital assets and inventory and iv) investment income and expenses
  - A subtotal for "operating income/(loss) and noncapital subsidies"
  - Government-wide schedule of natural classification of expenses would be presented as supplementary information (BTA activities by segment)

GASB major project – Revenue and Expense Recognition

Summary	Potential impact
• Three primary areas of focus of the project are as follows: 1. Common exchange transactions not specifically addressed in existing GASB guidance ➢ Project plans to develop guidance or improve existing guidance regarding i. Exchange and exchange-like transactions having single elements ii. Exchange and exchange-like transactions having multiple elements iii. The differentiation between exchange-like and non-exchange transactions 2. Post-implementation review of GASB 33 and 36 ➢ Areas to be considered include: i. Distinguishing between eligibility requirements and purpose restrictions ii. Determining when a transaction is an exchange or a nonexchange transaction iii. Using the availability period concept consistently across governments iv. Applying time and contingency requirements 3. Development of GASB conceptual framework ➢ GASB 33 and 36 were developed prior to key parts of the conceptual framework, such as defining deferred inflows and outflows ➢ An evaluation of the recognition of nonexchange transactions against the conceptual framework is necessary • Invitation to Comment has been issued, with a comment period through April 2018. Current projected release of a final statement is March 2023.	As it relates to recognition of exchange and nonexchange transactions such as grants vs gifts vs contracts, there continues to be an element of judgment and interpretation of existing GASB and FASB guidance. This project could impact the current practices of health care institutions as it relates to revenue recognition.

GASB pre-agenda research

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

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

Grant Thornton

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NYC HEALTH + HOSPITALS

OFFICE OF INTERNAL AUDITS

AUDIT COMMITTEE BRIEFING
JUNE 2019

Index

A. EXTERNAL AUDITS

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

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

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.

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.

All of the above documents were sent to the IRS as of February 7, 2019.

On May 28, 2019 we were advised that the field work was completed and forwarded to the IRS Audit Manager for review. After this review is completed, we will receive a closing letter with the findings and observations.

2. ***Children of Bellevue Auxiliary – NYC Comptroller's Office***

Audit Notification Letter Received – March 21, 2019
Preliminary Entrance Conference – April 4, 2019
Audit Status – On-going

The Audit Engagement Letter stated that the audit was of Children of Bellevue's (CoB) financial and operating practices. For Calendar Year 2017, the Balance Sheet for this Auxiliary shows Cash and Investments totaling over $1.25 million.

The twenty-two Auxiliaries that exist within the various facilities of NYC Health + Hospitals are separate 501c3 not-for-profit corporations whose primary function is to enhance the quality of patient care. They do this by receiving and administering funds received from fund raising activities, gifts, and donations and distributing those funds for activities or projects which enhance the quality of patient care and for selected amenities not otherwise available to patients.

The audit objectives are to determine whether CoB:

- Has adequate controls over and accurately reports its revenues and expenses.
- Is complying with applicable rules, regulations, policies and procedures.
- Has computerized systems controls to ascertain the integrity, validity and reliability of its data.

The walkthrough of Auxiliary operations was conducted on May 1, 2019. Financial documents and operating procedures related to the day-to-day activities of the Auxiliary are currently being requested.

B. OTHER AUDIT ACTIVITIES

1. Report Received from the Office of Inspector General

A report was received from the Office of Inspector General (IG) regarding their review of Unauthorized Parking Placards.

The report discussed three complaints received by the IG concerning specific members of Hospital Police staff who were fabricating, distributing and using unauthorized parking placards to avoid parking fines for themselves and individuals within Health + Hospitals and other New York City agencies. The staff involved were assigned to various facilities – NYC Health + Hospitals/ Elmhurst, North Central Bronx and Coney Island.

The IG believed the actions taken by these individuals violated NYC Health + Hospitals Code of Ethics and may violate conflicts of interest rules under Chapter 68 of the New York City Charter.

They suggested that Health + Hospitals management take the appropriate personnel action against the employees noted within the report. They also recommended that Health + Hospitals issue a system-wide advisory reminding all employees on the proper use of placards.

As a result of this report, a system-wide advisory was issued by the Corporate Compliance Officer to all employees on the authorized uses of parking placards. In addition, an internal investigation was initiated regarding the employees mentioned in the report with appropriate actions to be taken depending on the results.

2. Anonymous Letters

The Office of Internal Audits is currently investigating two anonymous letters received by the President's Office. The first letter included complaints about the purchasing habits of the Facilities Manager at NYC Health + Hospitals/Gouverneur. Discussions were held with Corporate Facilities Management and executive management at Gouverneur to obtain some background information. An evaluation of the purchasing history within this department is currently underway. This investigation is on-going.

The accusations in the second letter were about the Finance Director in MetroPlus. A meeting was held with the CEO and Compliance Director to obtain some background information regarding the Finance function. In addition, the Human Resources Director provided policies and procedures related to the hiring practices of MetroPlus.

AUDIT COMMITTEE OF THE NYC HEALTH + HOSPITALS BOARD OF DIRECTORS

Audit Committee Meeting

Corporate Compliance Report

June 13, 2019

AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
June 13, 2019 @ 11:00 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
June 13, 2019 @ 11:00 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

3) During the period from April 1, 2019 through May 31, 2019, the OCC was notified of three (3) disciplined community physicians and one (1) disciplined affiliate physician.

4) On May 9 and 10, 2019, the OCC received reports stating that two (2) community physicians had restrictions placed on their licenses, including one physician whose license was revoked, and a third previously reported disciplined community physician who recently surrendered his license voluntarily.

5) The restrictions for each of the community physicians included the following: (a) the revocation of one physician's license due to several incidents of misconduct; (b) a restriction for one physician which prohibits the supervision of a physician assistant and prohibits the incorporating, acquiring, owning or being a shareholder,

[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.

officer or partner of, more than one professional service corporation involving the practice of medicine; and (c) the surrendering of one physician's license due to misconduct related to fraud, conspiracy in the fourth degree, and the criminal sale of a prescription for a controlled substance. Consequently, the OCC coordinated with the Epic security team to ensure that NYC Health + Hospitals no longer receives referrals from these community physicians.

6) On May 10, 2019, the OCC was informed that an affiliate physician at NYC Health + Hospitals/Coney ("Coney") had a specific restriction placed on her license. This restriction precluded her from performing all forms of invasive procedures, including but not limited to injections, infusions, blood glucose tests with portable glucometers, and phlebotomy. The Chief Medical Officer at Coney was aware of this affiliate physician's restrictions, and her privileges were adjusted according to the Office of Professional Medical Conduct requirements. In addition, she has been placed on administrative leave until further notice.

Death Master File and National Plan and Provider Enumeration System Screening

7) 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.

8) No providers were identified on the DMF or NPPES since the last Audit Committee meeting.

II. Privacy Incidents and Related Reports

Breach Defined

9) A breach is an impermissible use, access, acquisition or disclosure (collectively referred to as "use and/or disclosure") under the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 Privacy Rule that compromises the security

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

10) Pursuant to 45 CFR § 164.402(2), unless an exception applies, 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.

Reported Breaches and HIPAA Violations

11) Since the last Audit Committee meeting, twenty-seven (27) incidents were entered in the System's RADAR Incident Tracking System. Of the twenty-seven (27) incidents, ten (10) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures ("OPs"), specifically OP 240-15 HIPAA Privacy Safeguards Policy, and OP 240-28 HIPAA Policy on Uses and Disclosures for Treatment, Payment and Healthcare Operations; ten (10) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security OPs; and seven (7) are still under investigation.

12) Of the 10 incidents confirmed as violations, three (3) were determined to be breaches.

- **NYC Health + Hospitals/Elmhurst ("Elmhurst") – March 2019**

Incident: This incident was brought to the OCC's attention on March 29, 2019 and occurred on March 28, 2019, when a resident physician allegedly disclosed a patient's HIV status in front of a family member present in the room without the patient's authorization. The patient filed a formal complaint with Patient Relations which was forwarded to Risk Management and the OCC.

Breach Determination: The OCC reviewed the patient complaint and spoke with the resident physician who couldn't expressly confirm whether or not this information was disclosed during the conversation he had with the patient. Due to the possibility that this disclosure may have occurred, the patient was notified of a breach on May 2, 2019.

Mitigation: The employee who potentially disclosed this information was required to complete the OCC's HIPAA online privacy and security remediation course and was provided with counseling by his supervisor.

- **NYC Health + Hospitals/Bellevue ("Bellevue") – April 2019**

Incident: This incident was brought to the OCC's attention on April 19, 2019, and occurred on April 17, 2019, when a contracted worker, who was on-site during the Epic Electronic Medical Record ("EMR") implementation, accessed the record of another contracted worker, who had become a patient while working at Bellevue. The contracted worker used the account of a Bellevue physician to access the patient's information, and the physician reported the incident to the OCC.

Breach Determination: The OCC reviewed the statements made by the contracted worker as well as the physician who reported the issue. Following an investigation, the OCC concluded that a breach had occurred, and notified the patient of the breach on May 2, 2019.

Mitigation: The OCC worked with HCI, the third-party company contracted to provide staff with Epic onsite assistance, to ensure that the contracted worker was removed from the Bellevue worksite, which was done immediately. Subsequently, HCI terminated this worker.

- **NYC Health + Hospitals/Queens ("Queens") – April 2019**

Incident: This incident was brought to the attention of the OCC on April 24, 2019 by Patient Relations, and occurred on April 18, 2019 when an employee provided a patient the discharge documents of another patient in the emergency department. The discharge documents included sensitive health information, prescription information, demographic information and diagnosis.

Breach Determination: The OCC reviewed the statements made by both patients and the treating nurse practitioner, as well as Epic chart audit trails. The case was substantiated and the documents were returned to the hospital. The patient was notified of a breach on May 2, 2019.

Mitigation: The OCC required the employee who provided the discharge documents to the wrong patient to complete the OCC's HIPAA online privacy and security

remediation course, and the employee's supervisor provided counseling to the employee.

Office for Civil Rights ("OCR") Reports

13) There was one (1) report received from the OCR in the since the last Audit Committee meeting. The report involved a complaint about an alleged HIPAA violation at NYC Health + Hospitals/Coler ("Coler") concerning unreasonable fees charged by Coler for access to a patient's medical records. The OCC is currently investigating the allegation and working with the Health Information Management department at Coler to recommend areas for process improvement with respect to access to medical records. The OCR is not taking any action regarding this complaint at this time.

14) In addition, as reported at the last Audit Committee Meeting, on February 22, 2019, the OCR met with the OCC and Enterprise Information Technology Services ("EITS") leadership, along with in house and outside counsel, to discuss NYC Health + Hospitals' compliance with HIPAA. The OCR called this meeting due to its concerns regarding NYC Health + Hospitals' ability to comply with HIPAA, and in particular, to safeguard its ePHI from inappropriate use or disclosure. During this meeting, however, we were able to explain to the OCR that the System has many controls in place to safeguard its ePHI, in compliance with HIPAA requirements. The OCR requested that the System document such current controls, as well as additional planned controls, in a Commitment Letter to the OCR. The OCC submitted a Commitment Letter to the OCR on March 4, 2019, with follow-up documentation on March 18, 2019, April 30. 2019, and June 7, 2019.

15) As part of the System's commitment to the OCR, the OCC has revised the System's HIPAA Privacy and Security Operating Procedures ("OPs"), nearly all of which were signed by Dr. Katz on May 31, 2019. Most of these OPs date back to 2003 or 2004. There were 42 OPs to be revised, many of which were merged, for a total of 25 revised OPs. There is still one OP left to be signed, which is currently being finalized and prepared for signature. This OP combines the mental health and genetic testing OPs and adds HIV-related information. Due to the sensitivity of this information, and the complexity of the OP, it has taken a slightly longer to complete.

III. Compliance Reports

Summary of Compliance Reports

16) Since the last Audit Committee meeting, there were seventy-six (76) compliance reports, two (2) (2.6%) of which were classified as Priority "A," [3] twenty-eight (28) (36.8%) were classified as Priority "B," and forty-six (46) (60.5%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints.

17) *Correctional Health Services:* The OCC received a report alleging that a psychiatrist in Correctional Health Services' ("CHS") Forensic Psychiatric Evaluation Court Clinic audio recorded, on "multiple occasions," evaluations of defendants, using her personal cell phone. The recordings were alleged to have been created without the consent of the defendants or their counsel. It was also alleged that the psychiatrist appeared in a New York State Supreme Court proceeding, during which she admitted that she recorded a defendant's 730 evaluation, which is an evaluation to determine an individual's competency to stand trial.

a. Following an investigation of this allegation, the OCC concluded that the psychiatrist had only audio-recorded one evaluation, and that, although she did not technically violate any existing law or policy regarding the audio-recording of forensic evaluations, her decision to record the defendant in the proceeding was inconsistent with the custom and practice of performing 730 evaluations.
b. The OCC recommended that the psychiatrist be disciplined in the form of counseling, and retraining on the custom and practice of conducting 730 evaluations. The OCC also recommended that CHS develop general policies and procedures for conducting 730 evaluations, if such policies and procedures are not currently in existence, and more specifically to develop policies regarding any form of recording 730 evaluations.

[3] 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.

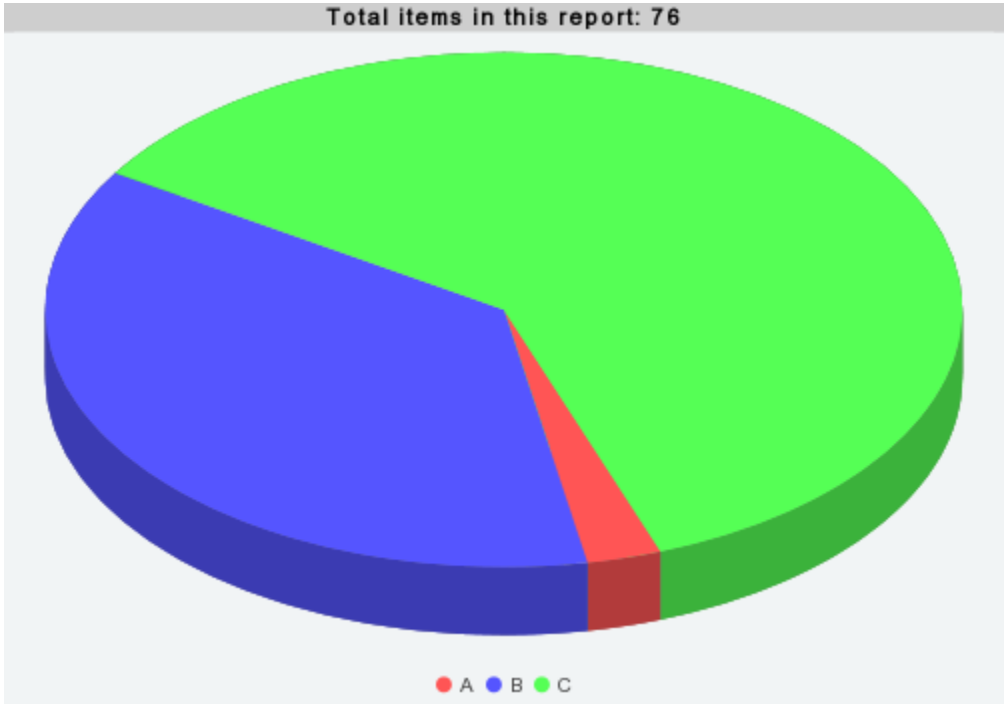
18) *NYC Health + Hospitals/Woodhull ("Woodhull"):* On April 17, 2019, the OCC received a report that a 23-year-old patient apparently committed suicide an hour after she was released from the Inpatient Psychiatric Unit at Woodhull. This matter was referred to the Chief Medical Officer and the Director of Risk Management at Woodhull.

a. The patient was discharged from Woodhull after a 25-day inpatient stay. The patient was diagnosed with schizophrenia, but only voiced having suicidal ideations on the first and second day of her inpatient stay. During her inpatient stay, the patient showed progressive improvement, attended and participated in assigned group therapy, and interacted with staff and peers appropriately. There was no significant event during her inpatient stay.
b. The day before the patient was discharged, there was a meeting with the patient's mother and stepfather, as well as the patient's outpatient therapist, and an appointment with the outpatient therapist was scheduled for 3:00 pm on the day of the discharge. All present agreed to the discharge plan, and therefore, the patient was discharged on April 10, 2019 at 11:00 am. The patient, however, was found on the street next to the housing project where she lived with her parents. There is an assumption that the patient jumped from a building near where she lived, but there were no witnesses to the incident. The patient was pronounced dead on arrival at Woodhull.
c. Because there were no witnesses to the incident, and the patient's family refused an autopsy for religious reasons, it is not known whether the patient jumped or was pushed, or whether any drugs were involved. It is also not known why the patient was at the building that she apparently jumped from, since the patient's apartment was in a different building within the complex.
d. On April 11, 2019, at 11:00 am, a meeting was held with Woodhull's Director of Risk Management, Chief Medical Officer, Associate Director of Quality, Chief of the Emergency Department, Chief of Pediatrics, Director of Patient Safety, Chief Nursing Officer's designee, the inpatient psychiatry physician, and the Director of Social Work, to discuss this incident. Members of the treating team were also present, including the psychiatrist, and representatives from nursing, social work and creative arts therapy. On April 22, 2019, a full root cause analysis meeting was held.
e. It was ultimately determined that the hospital handled the case appropriately, and that the discharge/safety plan was proper, so no corrective action was

necessary. H3 (Helping Healers Heal) support was provided to the behavioral health and ED staff. This incident was reported to the New York State Office of Mental Health by the Senior Associate Executive Director of Quality Management at Woodhull.

a. PRIORITY CLASSIFICATION

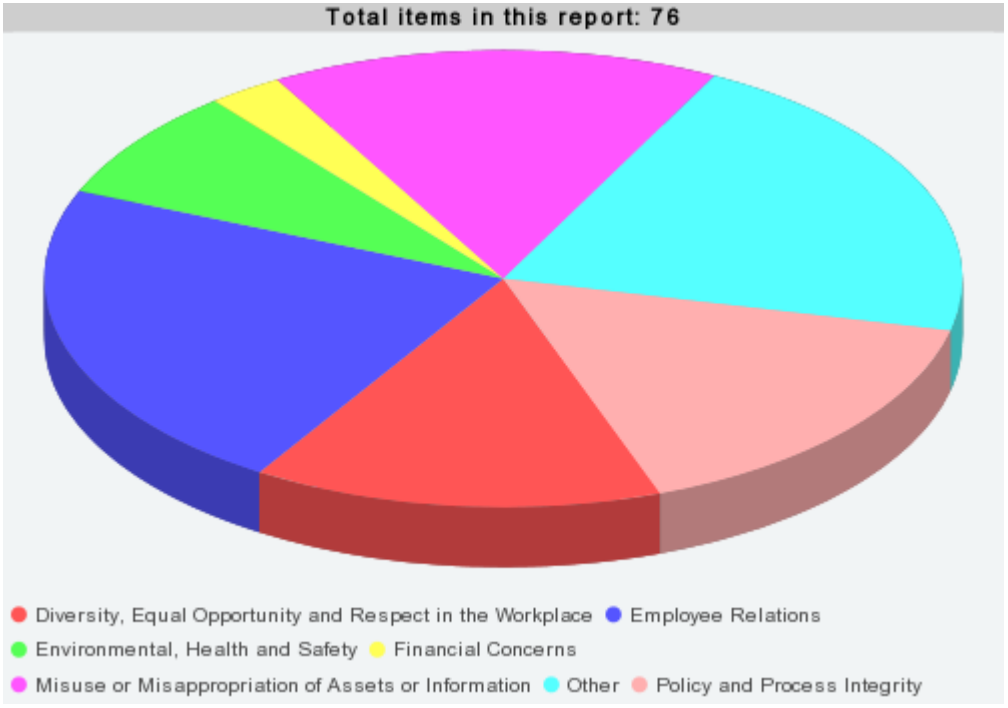
PRIORITY - CHART DATA		
	Frequency (Percentage)	
A	2.0 (2.6 %)	
B	28.0 (36.8 %)	
C	46.0 (60.5 %)	
Totals	76.0 (100%)	



b. PRIMARY ALLEGATION CLASS

PRIMARY ALLEGATION CLASS - CHART DATA

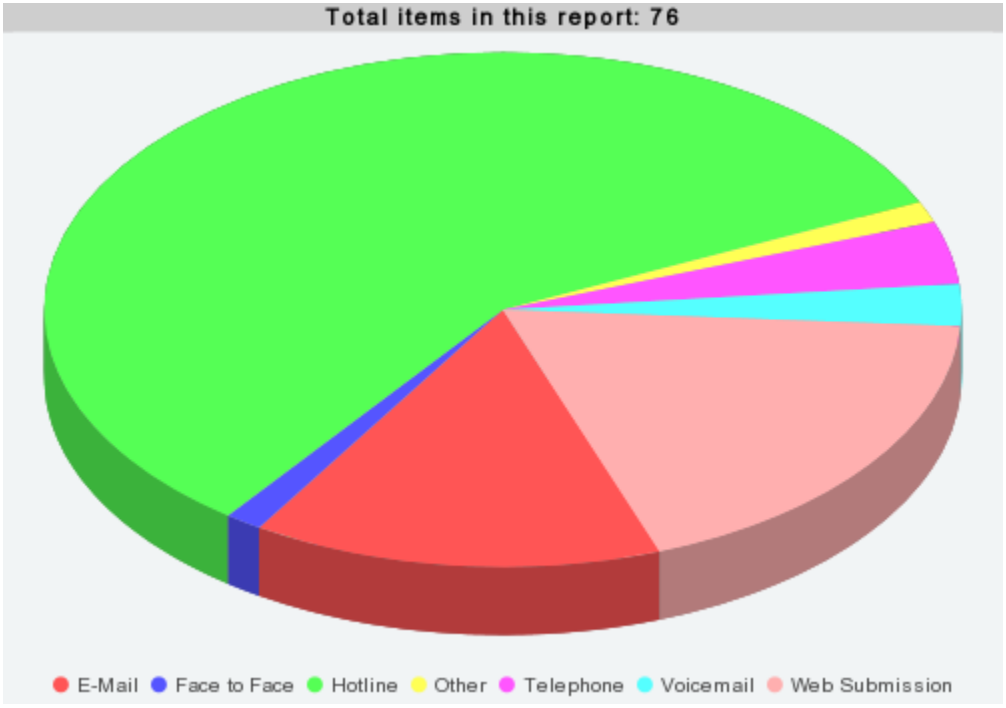
	Frequency (Percentage)
Diversity, Equal Opportunity and Respect in the Workplace	11.0 (14.5 %)
Employee Relations	17.0 (22.4 %)
Environmental, Health and Safety	6.0 (7.9 %)
Financial Concerns	2.0 (2.6 %)
Misuse or Misappropriation of Assets or Information	12.0 (15.8 %)
Other	16.0 (21.1 %)
Policy and Process Integrity	12.0 (15.8 %)
Totals	76.0 (100%)



c. PRIMARY ALLEGATION SOURCE

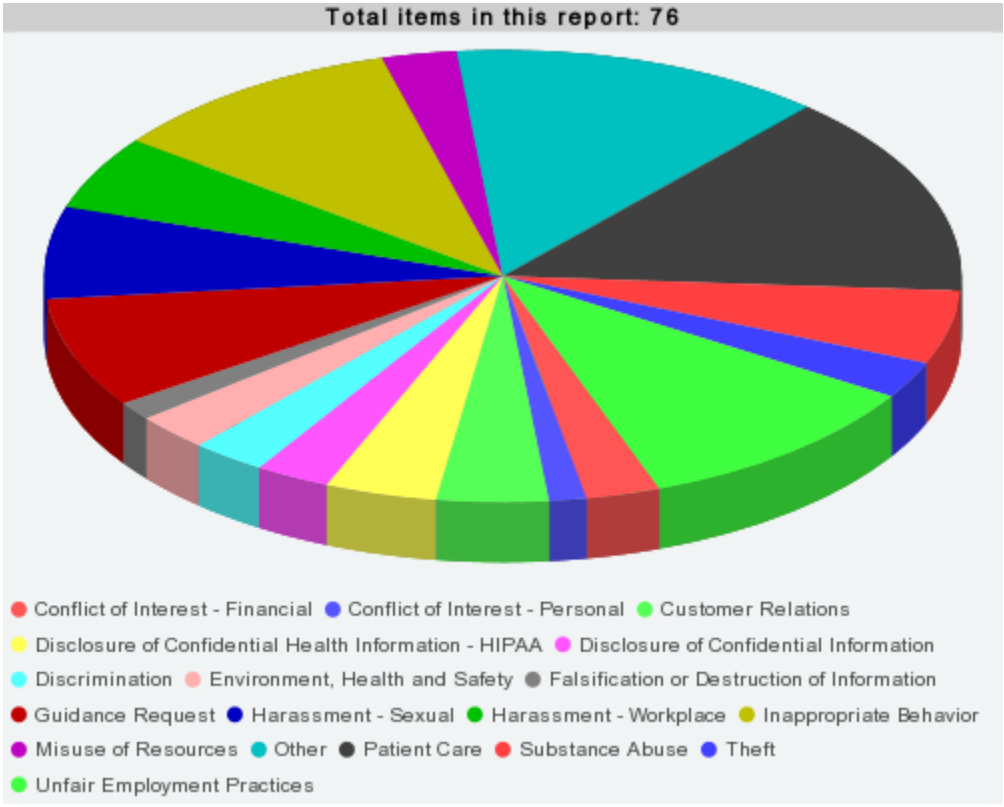
SOURCE - CHART DATA

	Frequency (Percentage)
E-Mail	11.0 (14.5 %)
Face to Face	1.0 (1.3 %)
Hotline	44.0 (57.9 %)
Other	1.0 (1.3 %)
Telephone	3.0 (3.9 %)
Voicemail	2.0 (2.6 %)
Web Submission	14.0 (18.4 %)
Totals	76.0 (100%)



d. PRIMARY ALLEGATION TYPE

PRIMARY ALLEGATION TYPE - CHART DATA	
	Frequency (Percentage)
Conflict of Interest - Financial	2.0 (2.6 %)
Conflict of Interest - Personal	1.0 (1.3 %)
Customer Relations	3.0 (3.9 %)
Disclosure of Confidential Health Information - HIPAA	3.0 (3.9 %)
Disclosure of Confidential Information	2.0 (2.6 %)
Discrimination	2.0 (2.6 %)
Environment, Health and Safety	2.0 (2.6 %)
Falsification or Destruction of Information	1.0 (1.3 %)
Guidance Request	6.0 (7.9 %)
Harassment - Sexual	5.0 (6.6 %)
Harassment - Workplace	4.0 (5.3 %)
Inappropriate Behavior	8.0 (10.5 %)
Misuse of Resources	2.0 (2.6 %)
Other	10.0 (13.2 %)
Patient Care	11.0 (14.5 %)
Substance Abuse	4.0 (5.3 %)
Theft	2.0 (2.6 %)
Unfair Employment Practices	8.0 (10.5 %)
Totals	76.0 (100%)



IV. Status Update – OneCity Health

Independent Assessor Audit of OneCity Health

19) In January 2019, an onsite audit on funds flow, workforce spending, and actively engaged patients was conducted by an Independent Assessor. On April 30, 2019, OneCity Health received its preliminary Audit Scorecard from the Independent Assessor, and submitted additional follow-up documentation to the Independent Assessor on May 31, 2019.

20) Upon receipt of the OneCity Health's response, the Independent Assessor will perform a review of the additional documentation submitted, and issue an Independent Assessor Onsite Audit Final Scorecard. If the Independent Assessor is unable to validate the documentation and reporting submitted by OneCity Health

in the quarterly reports, the Independent Assessor will recommend that the corresponding Achievement Values be overturned and the corresponding value will be withheld from future payment to the PPS.

OneCity Health's Partner Compliance Attestation

21) OneCity Health, as a PPS Lead in the DSRIP Program, is responsible for taking "reasonable steps to ensure that [M]edicaid funds distributed as part of the DSRIP program are not connected with fraud, waste, and abuse. It is reasonable for a PPS Lead to consider its network performing providers' program integrity systems when dedicating resources and developing the PPS Lead's systems."[4] To satisfy its compliance obligations as a PPS Lead, and to fulfill the requirements of the OMIG DSRIP compliance guidance, OneCity Health developed a compliance Attestation form, which is designed to assess its Partners' compliance with the program requirements.

22) OneCity Health Partners must certify annually to OneCity Health that they have met their DSRIP compliance training obligations and certain other compliance-related obligations. Accordingly, the OCC, on behalf of OneCity Health, distributed a Memorandum to OneCity Health Partners with a link to a *Compliance Attestation of OneCity Health Partners* ("Attestation"). The Attestation, which provides OneCity Health and the OCC with a critical snapshot of the compliance foundation of its DSRIP Partners, was required to be completed by all OneCity Health Partners and returned to the OCC by close of business April 30, 2019.

V. Status Update - HHC ACO, Inc.

23) HHC ACO, Inc. ("HHC ACO") submitted its application to renew its contract with CMS for the 2019-2024 agreement period. HHC ACO is applying to participate in the Enhanced Track of the Medicare Shared Savings Program ("MSSP"), beginning July 1, 2019. The Enhanced track is a two-sided track, which will involve shared savings as well as potential shared losses. The shared savings could be as much as

[4] Office of the Medicaid Inspector General Delivery System Reform Incentive Payment ("DSRIP") Program DSRIP Compliance Guidance 2015-01 –revised – Special Considerations for Performing Provider System ("PPS") Leads' Compliance Program available at: https://www.omig.ny.gov/images/stories/compliance_alerts/20150901_DSRIP_CompGuidance_2015-01_Rev.pdf.

75% of the savings to the Medicare program, adjusted by HHC ACO's quality score, and capped at 20% of total benchmark expenditure. Although the Enhanced Track provides for the most allowed shared savings, it also carries the most risk – amounting to 40% to 75% of the losses to the Medicare program. The losses, however, are also adjusted by HHC ACO's quality scores, and capped at 15% of the total benchmark expenditure imposed by CMS. The final submission date for the final round of requested documentation to CMS was May 2, 2019.

24) The ACO has been working to finalize its agreements and contracts to satisfy CMS' requirements to participate in the Enhanced Track, which will start on July 1, 2019 and end on December 31, 2024. HHC ACO expects to receive final approval from CMS on its application during the week of June 17, 2019.

25) On April 15, 2019, the HHC ACO Board of Directors met and passed a resolution authorizing HHC ACO to furnish any required repayment mechanism and authorize the CEO of HHC ACO to execute and deliver the required repayment mechanism on behalf of HHC ACO Inc.

26) On April 18, 2019, NYC Health + Hospitals' Board of Directors met and passed a resolution to authorize NYC Health + Hospitals to become the guarantor for the MSSP repayment mechanism. On May 21, 2019, HHC ACO received preliminary approval from CMS, status pending finalization of the repayment mechanism. On May 30, 2019, HHC ACO finalized the transaction with TD Bank to issue a letter of credit to CMS to satisfy the requirement of establishing a repayment mechanism.

27) On May 2, 2019, HHC ACO submitted responses to the New York State Department of Health for the annual questionnaire to maintain All Payer ACO status with New York State.

VI. HIPAA Risk Analysis and Security Assessment

28) To ensure the System's compliance with the requirements of HIPAA and HIPAA regulations, the System has engaged a third party vendor, Coalfire Systems, Inc. ("Coalfire"), to conduct a HIPAA enterprise-wide Risk Analysis and Security Assessment. Coalfire conducted its corporate review in April 2019, and began conducting facility on-site reviews on May 8, 2019. Coalfire will conduct on-site

reviews at all of the System's acute care facilities, skilled nursing facilities, and Diagnostic and Treatment Centers, and a sample of the Gotham clinics. It will also conduct virtual reviews of 14 other Gotham clinics.

29) In addition, Coalfire will perform penetration tests of the System's systems and applications to determine their vulnerability to unauthorized access. It will also assess a sample of the System's vendors to determine their compliance with HIPAA and the security of the System's PHI that they maintain.

VII. Aetna Desk Review

30) As previously reported, on January 31, 2018, the OCC received a Notice of Compliance Program Audit (the "Notice") from Aetna, requesting information from the System relating to its compliance with Medicare Parts C and D 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. These reviews are conducted under the auspices of their "Delegated Vendor Oversight" responsibilities, as required by CMS.

31) 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.

32) 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.

33) 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 NYC Health + Hospitals.

34) 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 within the past ten years, by February 15, 2019. The OCC provided information to Aetna on February 15, 2019.

35) On April 8, 2019, Aetna sent the OCC another email stating that (i) Aetna had completed its assessment of the System's compliance with general Medicare compliance program requirements; (ii) Aetna's National Network Delegation auditors conducted a thorough review of the evidence provided by the System and determined that the System demonstrated compliance training dating back to 2009 for four of the five selected employees, but that gaps were identified in training completion during some years; and (iii) Aetna's review of the System's evidence demonstrating completion of compliance training within the past ten (10) years did not meet the Corrective Action Plan ("CAP") requirements for the System's record retention policy. Aetna further noted that the CAP would remain open, and requested that the System advise Aetna if there will be any additions or revisions to its policy and procedure to address the identified deficiencies.

36) The OCC responded to this email on April 30, 2019, explaining the reasons for any gaps in training completion, and that the System has taken significant mitigation steps. These include the development of new courses, processes, and workforce requirements, all which were launched in 2018, which were designed and implemented to prevent the reoccurrence of any such issues going forward.

37) In addition, the OCC stated in its response that it did not agree that the System did not meet the needs of the CAP requirements for the System's record retention policy, or that the record retention requirements had not been met. Specifically, the OCC stated that Operating Procedure 120-19 *Corporate Records Management Program And Guidelines For Corporate Record Retention and Disposal,* previously provided to Aetna, was developed and went into effect as part of an effort to ensure that the System meets various regulatory and legal requirements. However, the development and implementation of such Operating Procedure occurred after the time period that Aetna selected for review, and future reviews should not yield the same findings.

38) Finally, the OCC stated that the measures taken by the System provide sufficient evidence that the System is working to both enhance and support its compliance with applicable regulations. Due to the mitigation steps already implemented, and the CAP now in place, the OCC stated that it is of the opinion that no additions or revisions to the System's policy and procedure are warranted. The OCC also requested that Aetna close out the CAP and deem all the purported deficiencies to be resolved. We are currently awaiting Aetna's response to the OCC.