NYC HEALTH + HOSPITALS

AUDIT COMMITTEE
MEETING AGENDA

February 6, 2020
10:00 A.M.

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

CALL TO ORDER	Ms. Helen Arteaga Landaverde
• Adoption of Minutes December 12, 2019	Ms. Helen Arteaga Landaverde
INFORMATION ITEMS	
• Audits Update	Mr. Chris A. Telano
• Compliance Update	Ms. Catherine Patsos
EXECUTIVE SESSION	
OLD BUSINESS	
NEW BUSINESS	
ADJOURNMENT	

MINUTES

AUDIT COMMITTEE

MEETING DATE: December 12, 2019
TIME: 10:00 A.M.

COMMITTEE MEMBERS
Jose Pagán, PhD
Mitchell Katz, MD

OTHER MEMBERS OF THE BOARD
Sally Hernandez-Piñero
Freda Wang
Feniosky Peña-Mora

STAFF ATTENDEES
Colicia Hercules, Chief of Staff, Chairman's Office
Andrea Cohen, General Counsel
Jay Weinman, Corporate Comptroller
James Linhart, Deputy Corporate Comptroller
Marji Karlin, Chief Revenue Officer
Nicole Fleming, Controller, Finance
Catherine Patsos, Chief Compliance Officer
Christopher A. Telano, Chief Internal Auditor
Devon Wilson, Senior Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
John Cuda, Chief Financial Officer, MetroPlus
Lilly Pham, Senior Assistant Controller, MetroPlus
Kevin Lynch, Senior Vice President, EITS
Jeffrey Lutz, Assistant Vice President, EITS
Bard Qarri, Senior Director, EITS
Arthur Fields, Director, EITS
Jonathan Goffin, Director, EITS
Keriann Purnell, Coordinating Manager, EITS
Michael Cosmi, Director, Information Services, At Home

OTHER ATTENDEES
Grant Thornton: Tami Radinsky, Lead Engagement Partner; Lou Feuerstein, Relationship Partner; Sandy Pabla, Manager IT

AUDIT COMMITTEE TALKING POINTS
DECEMBER 12, 2019

Call to Order

Mr. José Pagán, Board Chair called the meeting to order at 10:08 A.M.

Members in attendance: José Pagán, Mitchell Katz, Freda Wang – in a voting capacity for Helen Arteaga Landaverde, Sally Hernandez-Piñero, Feniosky Peña-Mora

CORPORATE COMPLIANCE UPDATE

Ms. Patsos began her update with Monitoring Excluded Providers – As required by the Federal and state regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General ("OMIG")1 and the U.S. Department of Health and Human Services Office of Inspector General ("OIG"), each month the Office of Corporate Compliance ("OCC") reviews the exclusion status of the System's workforce members, vendors, and New York State Department of Health ("DOH") Delivery System Reform Incentive Payment ("DSRIP") Program Partners.

During the period from September 21, 2019 through November 22, 2019, there was one excluded vendor. On September 24, 2019, the OCC was notified that a vendor providing hospice services was terminated from participating in the Medicare program, effective May 31, 2019. There were no payments to this vendor after this date; therefore, no overpayment or disclosure is required. Supply Chain Services has inactivated this vendor in their database.

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.

Privacy Incidents and Related Reports

During the period of September 21, 2019 through November 22, 2019, twenty-one (21) incidents were entered in the System's RADAR Incident Tracking System. Of the twenty-one (21) incidents entered in the tracking system, eighteen (18) were found after investigation, to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures ("OPs"); one (1) was found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security OPs; and two (2) are still under investigation.

Of the eighteen (18) incidents confirmed as violations, eight (8) were determined to be breaches. These breaches involved giving a prescription to the wrong patient, sending medical records to the wrong law firm, disclosure of a patient's medical condition in the presence of another individual not authorized to receive this information, and giving After Visit Summaries to the wrong patients.

In addition, on October 3, 2019, the NYC Health + Hospitals Office of the Inspector General ("IG") was informed that, between 2016 and November 2019, an employee at NYC Health + Hospitals/Jacobi disclosed the PHI of an unknown number of NYC Health + Hospitals' patients. The IG informed NYC Health + Hospitals of this incident on November 7, 2019. Specifically, the information that was disclosed included patients' names, telephone numbers, and the fact that they had been in motor vehicle accidents.

The OCC was able to obtain the names and telephone numbers of approximately 300 affected individuals, approximately 200 of which the OCC was able to match with addresses. These affected individuals were notified of this breach on December 2, 2019. In addition, a substitute notice has been placed on NYC Health + Hospitals' public website, which includes the circumstances of the breach and a toll free number to call for additional information. An internal investigation is ongoing, and appropriate disciplinary action will be taken.

Office for Civil Rights ("OCR") Reports Regarding HIPAA Incidents

Since the last Audit Committee meeting, the OCC received one report from the OCR regarding a HIPAA incident at NYC Health + Hospitals/Bellevue ("Bellevue"). The report, dated September 17, 2019, concerned a patient's complaint that Bellevue failed to provide access to the patient's medical records. Although the OCR closed this matter, the OCC investigated it and learned that the patient did in fact receive some of his electronic records on August 29, 2019, and Bellevue has provided him with his remaining medical records. The OCC will send a response to the OCR explaining the circumstances of the complaint and the actions taken to remediate the issue.

Compliance Reports

For the period of September 21, 2019 through November 22, 2019, there were fifty-six (56) compliance reports, one (1) (2%) of which was classified as Priority "A,"2 seventeen (17) (30%) were classified as Priority "B," and thirty-eight (38) (68%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints.

Status Update on OneCity Health

OneCity Health, as a PPS Lead in the DSRIP Program, 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. To satisfy its compliance obligations as a PPS Lead, and to fulfill the requirements of the OMIG DSRIP compliance guidance, OneCity Health has 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. Accordingly, the OCC, on behalf of OneCity Health, will distribute a Memorandum to OneCity Health Partners early next year, 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, is required to be completed by all OneCity Health Partners.

Status Update - HHC ACO, Inc.

On September 30, 2019, HHC ACO, Inc. ("HHC ACO") received its PY2018 performance report, indicating that it had successfully earned shared savings for six years in a row. In PY2018, HHC ACO reduced costs for its Medicare beneficiaries by $7.26 million, of which it earned $2.97 million in shared savings (this compares to $2.18 million in

PY2017). In addition, HHC ACO is the only ACO based in New York State to earn shared savings over six consecutive years, and one of the only 18 ACOs around the country to have earned that distinction.

On October 1, 2019, HHC ACO submitted its quality measures to NYS Department of Health ("DOH") to satisfy DOH's Quality Assurance Reporting Requirements (QARR) for the following measures:
a. Breast Cancer Screening;
b. Colorectal Cancer Screening;
c. Controlling High Blood Pressure; and
d. Diabetes: Hemoglobin A1c Poor Control.

HIPAA Risk Analysis and Security Assessment

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 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 Health clinics. It also conducted virtual reviews of fourteen (14) other Gotham Health clinics.

In addition, Coalfire has performed penetration tests of the System's systems and applications to determine their vulnerability to unauthorized access. It is also assessing a sample of the System's vendors to determine their compliance with HIPAA and the security of the System's PHI that they maintain.

Coalfire has been submitting draft reports of its findings, and expects to submit final reports by the end of this year.

National Corporate Compliance and Ethics Week 2019

The OCC commemorated National Corporate Compliance & Ethics Week from November 4th to 8th. This year's Corporate Compliance and Ethics Week theme, ***Awareness, Recognition, Reinforcement,*** embodied key elements of the OCC's work towards increasing the prominence of compliance concerns, acknowledging the duty to report them, and emphasizing the importance of professional and ethical conduct in carrying out our duties and responsibilities.

Mr. Pagán stated that 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 designate, Ms. Freda Wang in a voting capacity, as having her vote at this meeting.

Mr. Pagán asked for a motion to adopt the minutes of the Audit Committee meeting held on October 10, 2019. A motion was made and seconded with all in favor to adopt the minutes.

Grant Thornton Management Letter

Ms. Radinsky presented by outlining the observations and recommendations.
There are three levels of internal control deficiencies:

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

We are happy to report that there are no Material Weakness. We identified the following significant deficiency:

Grants Revenue Not Properly Recognized

Observation

We noted that the Grants Department was not consistently applying the accrual basis of accounting relating to grant revenue recognition. As a result, we proposed an audit adjustment reducing grant revenue by approximately $8 million which is not reflected in the June 30, 2019 financial statements since the amount was not considered material to the financial statements.

Recommendation

We recommend that management, on a periodic basis and at year end, review all expenses related to expense reimbursement contracts to ensure that the revenue and accounts receivable related to these expenses are properly recognized in the same period that the expenses are recorded. In addition, communications should be enhanced between the Grants Department and the Corporate Comptroller's Office to ensure timely, proper and complete accounting for grant revenue.

Status of Prior Year Findings/Observations:

Accounts Payable has been closed as well as *Patient Accounts Receivable and Net Patient Service Revenue – Controls over manual data entry into the patient accounting system*.

Still open and Management is working on them are the *Patient Accounts Receivables and Net Patient Service Revenue – Credit Balances* and *Patient Revenue recorded after fiscal year end for services prior to fiscal year-end .*

Information Technology

Unidentifiable Users

Observation

Upon reviewing the Soarian active account listing, we were unable to locate one employee that had an active Soarian administrator account.

Recommendation

We recommend that all user accounts should be reviewed and accounted for to ensure only appropriate and active users have access.

Segregation of Duties

Observation

We noted that seven PeopleSoft users with direct data access also maintain security administrator privileges.

Recommendation

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

User Access Review

Observation

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

Recommendation

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

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

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

User Administration

Observation

New Hires

Although a ticketing system is in place, management was unable to provide adequate documentation for all of the new hire sample we selected for testing. We recommend that IT maintain complete documentation regarding all newly hired personnel. In the event that application access was added post hire, any changes to user access rights should be documented and approved by appropriate stakeholders.

Terminations

Although a ticketing system is in place, management was unable to provide adequate documentation for all of the termination sample we selected for testing.

Recommendation

We recommend that the business units and/or Human Resources notify IT of terminated employees in a timely manner (e.g., within 24 hours) so that IT may disable/remove the terminated users' access as soon as possible to prevent unauthorized access into the Organization's systems.

INTERNAL AUDIT UPDATE

Mr. Telano reported on external audits by outside regulatory agencies. The first is the Children of Bellevue Auxiliary – NYC Comptroller's Office. This review has been in effect since April of this year, is already 8 months old and counting. They continue to do testing and are awaiting for the Audited Financial Statements from the CPA firm BKD before they finish their review. I have no comments on findings or anything related to the review.

The second audit is a follow-up of Nurse Hiring and Retention – NYC Comptroller's Office. This audit is winding up. They are reviewing certain documents and they visited three sites (Community Care, Gouverneur and Kings County). They are done with the fieldwork. We have a wrap up meeting scheduled for tomorrow (Friday) in which they will discuss their findings.

Other activities within Internal Audits

Auxiliary Audits – The Office of Internal Audits has had the responsibility to hire an outside CPA firm to certify the financial statements of all 22 Auxiliaries. Loeb & Troper was hired 4 years ago to undertake these audits. Since their merger with BKD in late 2018, their performance has declined to the point that only one (1) audit has been completed for the Calendar Year 2018 financial statements.

As a result of this poor performance, it has been decided that the 5th year option on the contract would not be exercised. It has also been determined that only 11 of the 22 Auxiliaries require a review or audit of their financial statements by a CPA firm. Prior to the new RFP being rolled out, a determination has to be made whether 11 or 22 reviews/audits will be conducted.

Ultimately, the firm selected will require approval by the Audit Committee.

Anonymous Letters

An anonymous letter was received from the President's Office, regarding improper payroll procedures in the Nursing Department at NYC Health + Hospitals/Elmhurst. An Audit Memorandum was issued to the President/CEO discussing the results of the investigation.

Two other anonymous letters were received but the investigations were already being done by the Inspector General and an external consulting firm.

EXECUTIVE SESSION:

At this point the Chair requested a motion to convene an executive session to discuss confidential and privileged matters that may be related to anticipated or actual litigation, as well as certain personnel matters.

Second, opposed, the motion is carried.

Thank you everyone and asked that only those specifically invited remain in the Boardroom.

OPEN SESSION:

The Committee re-convened in open session.

There being no other business, the meeting was adjourned at 11:04 A.M.

NYC HEALTH + HOSPITALS

OFFICE OF INTERNAL AUDITS

AUDIT COMMITTEE BRIEFING
FEBRUARY 2020

Index

A. EXTERNAL AUDITS

1. *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.

Many financial documents and operating procedures related to the day-to-day activities of the Auxiliary have been requested and reviewed. The most recent documents requested included the following:

- Conflict of interest disclosure forms as completed by the Children of Bellevue board members for Calendar Year 2018.
- The contract between Health + Hospitals and BKD/Loeb and Troper, LLP which pertains to the audits of its auxiliaries for Calendar Year 2018.
- All HHC policies and procedures related to auxiliaries in effect during the audit scope period of Calendar Year 2018; and,
- All draft policies as applicable to the auxiliaries.

It appears that the Comptroller's Office is waiting for the audited financial statements for Calendar Year 2018 before completing their review.

2. ***Follow-up Review of Nurse Hiring and Retention – NYS Comptroller's Office***

Original Report Date – July 16, 2018
Audit Notification Letter Received – October 8, 2019
Entrance Conference – October 22, 2019
Final Report Received – January 3, 2020

The Office of Internal Audits acts as the liaison between the New York State Comptroller's Office and the areas being audited within NYC Health + Hospitals. Our role is to arrange and attend all relevant meetings, ensure all audit requests are adhered to in a complete and timely manner, review all documents for completeness prior to them being sent to the Auditors, and coordinate the written responses to any audit findings.

The objective of this audit was to determine that the responses to the recommendations from the original audit were being acted upon. The audit included reviewing both direct hire and temporary nurses.

The initial report included four (4) recommendations of improvement. During the follow-up audit, it was determined that two (2) recommendations were Fully Implemented and two were Partially Implemented.

Recommendation #1 – *Ensure all temporary and direct hire nurses are electronically fingerprinted so they can be properly monitored for potential criminal activity.*

Status: Partially Implemented – The Auditors reported that although steps were taken to ensure that direct hire nurses who began after 2002 are electronically fingerprinted, action was not taken to ensure that direct hire nurses who began before 2002 were fingerprinted, to allow for ongoing monitoring of potential criminal activity. This comment was also reported during the initial audit.

Their testing of fingerprinting for direct hire nurses (at Community Care, Kings County and Gouverneur) revealed only 4 of 60 could not be found. The results of 25 temporary nurses revealed 6 could not be found and 12 had attestations on file that they were fingerprinted; the remaining 7 were confirmed.

Recommendation #2 – *Require facilities to complete and maintain documentation supporting that all background check requirements for (direct hire) nurses are met for their hiring.*

Status: Fully Implemented – The audit testing revealed no material findings.

Recommendation #3 – *Ensure facilities maintain complete readily available files for temporary nurses, and document evidence that staffing agencies background investigations have been reviewed by Health + Hospitals officials.*

Status: Partially Implemented – Although Health + Hospitals officials indicated that they are now maintaining background information for temporary staffing agency nurses, files were found not complete.

Employment eligibility verification documentation was on file for 16 of 25 sampled temporary nurses and background check documents from OIG, OMIG and SAM were found for 22. Evidence was found that Health + Hospitals employees also reviewed this background information for 15 of 25 sampled temporary nurses.

Recommendation #4 – *Require facilities to complete and maintain evidence of annual performance evaluations of direct hire and temporary nurses assigned for more than one year.*

Status: Fully Implemented – The audit testing revealed no material findings.

B. COMPLETED AUDITS

1. Follow-up Audit of Vehicles Owned & Leased by NYC Health + Hospitals (Original Report Issued 5/14/18) (Follow-up Report Issued 1/17/20)

The purpose of the follow-up audit was to ensure that action was taken to address the issues noted during the original audit. The status of each initial Audit Observation is as follows:

a) Excessive Number of Vehicles

Original Audit Observation: Our original review revealed that there were almost 450 vehicles being used throughout the System. There were over 100 vehicles controlled by Central Office Transportation and more than 300 vehicles were assigned to the facilities although there were a significant less amount of Motor Vehicle Operators.

Status: Partially Resolved – Central Office reduced their fleet by 23 (20%) vehicles; the facilities reduced their fleet by 34 (10%). Some sites (Harlem, Jacobi, Sea View) plan on reducing their fleet when vehicles currently in use are no longer useful; however, this may not occur within the near future. A full inventory of the system-wide vehicles has not yet been completed. A determination can me made of the full opportunity for improvement until this is done.

b) Purchasing vs. Leasing Vehicles

Original Audit Observation: During the course of the original audit, an analysis performed by Corporate Budget showed that it is financially sound to lease vehicles over purchasing. The analysis considered maintenance cost, wear and tear and insurance in determining their conclusion. The Vice President of Supply Chain Services responded that leasing would be implemented as the preferred method of procurement for New York City Health + Hospitals vehicles and purchasing methodology would only be utilized when specific funding rules require it.

Status: Partially Resolved – Although there have been no vehicles bought since July 1, 2018, no official policy has been rolled out mandating that, for the most part, all acquired vehicles are to be leased and not purchased.

c) Excessive Maintenance Costs

Original Audit Observation: The Central Office Transportation Unit utilizes a Global Fleet Management Service (ARI) contracted by the NYC Department of Citywide Administrative Service (DCAS) to manage the preventive maintenance of their fleet. ARI's maintenance management offers an open network with access to over six hundred (600) repair vendors

within the five boroughs. For all repair vendors, ARI Technicians scrutinize each requested repair, parts and labor for accuracy and cost savings.

The facilities are not utilizing the ARI service, instead they are using outside vendors for maintenance. For example, Harlem used repair shops located in Brooklyn, rather than one closer to the facility.

Status: Unresolved – Only two facilities (Queens and Elmhurst) have started utilizing the ARI service. While one or two other facilities have expressed interest, there has been no directive from Executive Management requiring all facilities to make use of this maintenance management program. We recommend that the Sr. Vice President of Capital Projects, Construction & Design issue a new System-wide policy to address this.

d) <u>Policies & Procedures Need Updating</u>

Original Audit Observation: There were no policies and procedures in place to indicate which personnel may have a vehicle assigned to them and the criteria required in determining when a new vehicle is needed. In addition, policies did not address the manner in which to obtain a vehicle (lease or purchase) or the maintenance program.

The Automobile Policy (Operating Procedure 170-2) has not been updated since September 1997. The Vice President of Facilities Development responded that the policy would be updated to include this situation.

Status: Unresolved – The Automobile Policy has not been updated. Although a draft was submitted for review in April 2018, a final version was never rolled out.

Therefore, we further recommend that the policy be brought up to date and address, at a minimum, all of the previously mentioned issues within the report:

1. Requiring all vehicles obtained be done so via leasing;
2. ARI maintenance management should be utilized for all vehicles throughout the System;
3. A set criteria should be established stating which personnel may have a vehicle assigned to them and when a vehicle should be replaced with a new one.

C. OTHER AUDIT ACTIVITIES

1. Auxiliary Audits

As mentioned during the last Committee meeting, it has been decided that the 5th year option on the contract of the CPA firm (BKD) conducting the Auxiliary audits would not be exercised due to poor performance. The RFP process has been initiated to select a new firm to conduct the audits for Calendar Year (CY) 2019. When the process is finalized, the firm selected will require approval by the Audit Committee.

Thus far, BKD has only certified the CY 2018 financial statements for 2 of the 22 Auxiliaries. They noted the following management letter comments for the audits completed:

Lincoln Hospital Auxiliary

a) Commission revenue and receivables were overstated on the Auxiliary accounting records. This was corrected during the audit.
b) A segregation of duty issue existed as the Assistant Director has access to purchasing, account payables, cash receipts and accounts receivable records due to staffing issues. Other compensating controls, such as approvals by the Auxiliary President before processing, already existed to prevent errors or fraud.

Auxiliary to Coney Island Hospital

a) A segregation of duty issue existed as the Coordinating Manager has access to purchasing, account payables, cash receipts and accounts receivable records due to staffing issues. Compensating controls will be implemented to address this.
b) A grant liability was mistakenly included within the financial records as of the beginning of the year. This was corrected during the audit.

AUDIT COMMITTEE OF THE NYC HEALTH + HOSPITALS BOARD OF DIRECTORS

Audit Committee Meeting

Corporate Compliance Report

February 6, 2020

AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
February 6, 2020 @ 10:00 AM

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AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS
Corporate Compliance Report
125 Worth Street, Room 532
New York, NY 10013
February 6, 2020 @ 10:00 AM

I. Monitoring Excluded Providers

Responsibilities of the System for Sanction List Screening

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

Exclusion and Sanction Screening Report Nov. 23, 2019 through Jan. 15, 2020

3) During the period from November 23, 2019 through January 15, 2020, there were no excluded individuals or entities.

Death Master File and National Plan and Provider Enumeration System Screening

4) 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.

5) No providers were identified on the DMF or NPPES during the period November 23, 2019 through January 15, 2020.

II. Privacy Incidents and Related Reports

Breach Defined

6) 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.

7) 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.[1]

Reported Breaches for the Period of Nov. 23, 2019 through Jan. 15, 2020

8) During the period of November 23, 2019 through January 15, 2020, twenty-eight (28) incidents were entered in the System's RADAR Incident Tracking System. Of the twenty-eight (28) incidents entered in the tracking system, ten (10) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy and Security Operating Procedures ("OPs"); nine (9) were found not to be a violation of NYC Health + Hospitals HIPAA Privacy and Security OPs; and nine (9) are still under investigation.

9) Of the ten (10) incidents confirmed as violations, seven (7) were determined to be breaches. These breaches involved providers viewing the medical records of patients not under their care; sending the wrong medical records to a medical records retrieval company, disclosure of a patient's information via unsecured email to an unintended recipient; disclosing a patient's PHI to the patient's visitor who was not authorized to receive such information; and patient records sent to the wrong law firm.

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

Office for Civil Rights ("OCR") Reports Regarding HIPAA Incidents

10) As reported at the last Audit Committee meeting, the OCC received one report from the OCR regarding a HIPAA incident at NYC Health + Hospitals/Bellevue ("Bellevue"). The report, dated September 17, 2019, concerned a complaint from a patient's lawyer that Bellevue failed to provide access to the patient's medical records. Although the OCR closed this matter, the OCC investigated it and learned that, in addition to the medical record request, the lawyer sought to obtain an audit trail of individuals who had accessed her client's medical records, and billing records for his care and treatment at Bellevue. The OCC also learned that the lawyer did in fact receive the patient's medical records on August 29, 2019, which was prior to her complaint to the OCR. The only remaining information to be sent to the attorney was an audit trail of access to the patient's medical records, which HIPAA does not require covered entities to provide.

11) The same attorney made a similar complaint to the OCR on October 2, 2019, about which the OCR informed Bellevue via letter dated November 26, 2019. This letter, however, specifically requested a detailed response to the complaint with accompanying evidence. The OCC responded to the OCR on January 17, 2020, and explained that NYC Health + Hospitals had provided the complainant with her client's medical records on multiple occasions, and provider her with certified billing records on two occasions.

III. Compliance Reports

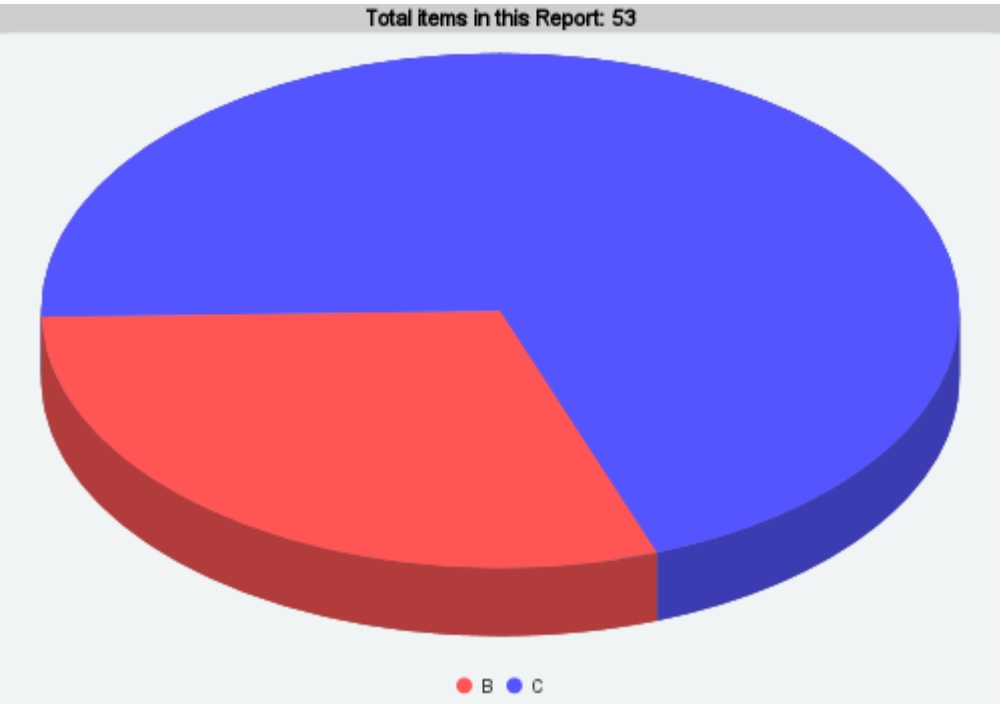
Summary of Reports for the Period of Nov. 23, 2019 through Jan. 15, 2020

12) For the period of November 23, 2019 through January 15 2020, there were fifty-three (53) compliance reports, none of which was classified as Priority "A,"[2] sixteen (16) (30.2%) were classified as Priority "B," and thirty-seven (37) (69.8%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints.

[2] 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.

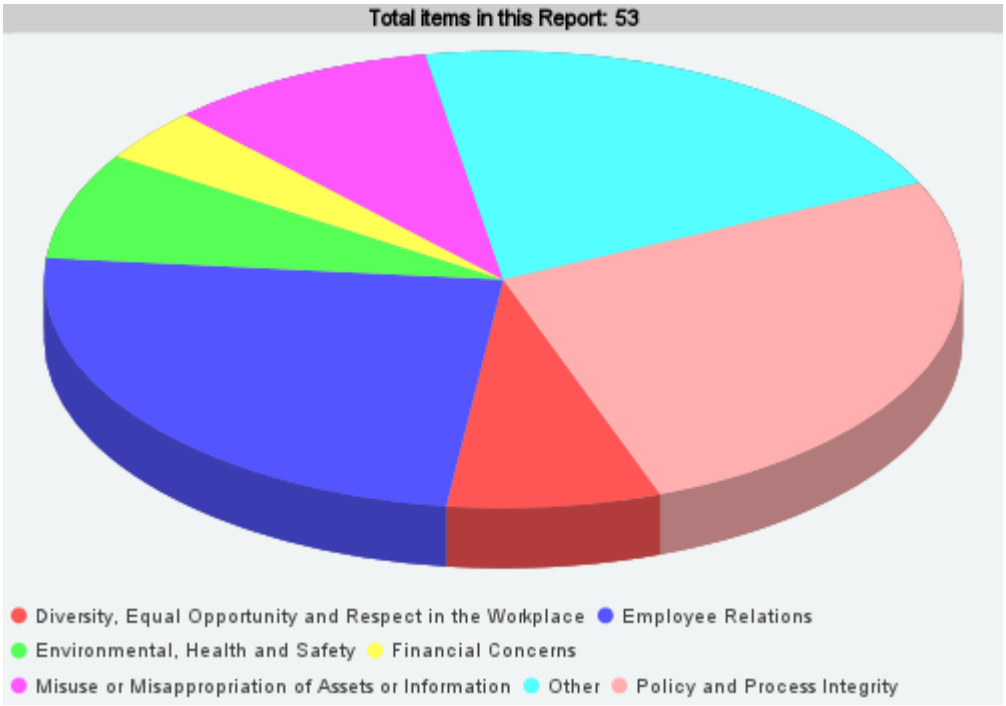
a. PRIORITY CLASSIFICATION

PRIORITY - CHART DATA	
	Frequency (Percentage)
B	16.0 (30.2 %)
C	37.0 (69.8 %)
Totals	53.0 (100%



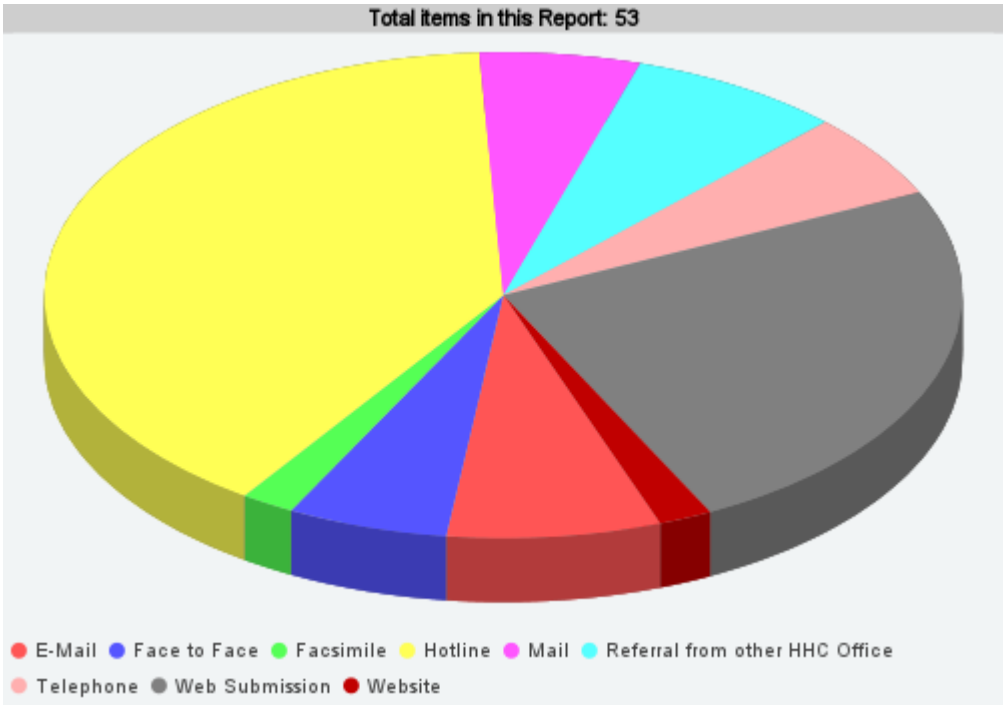
b. PRIMARY ALLEGATION CLASS

PRIMARY ALLEGATION CLASS - CHART DATA	
	Frequency (Percentage)
Diversity, Equal Opportunity and Respect in the Workplace	4.0 (7.5 %)
Employee Relations	13.0 (24.5 %)
Environmental, Health and Safety	4.0 (7.5 %)
Financial Concerns	2.0 (3.8 %)
Misuse or Misappropriation of Assets or Information	5.0 (9.4 %)
Other	11.0 (20.8 %)
Policy and Process Integrity	14.0 (26.4 %)
Totals	53.0 (100%)



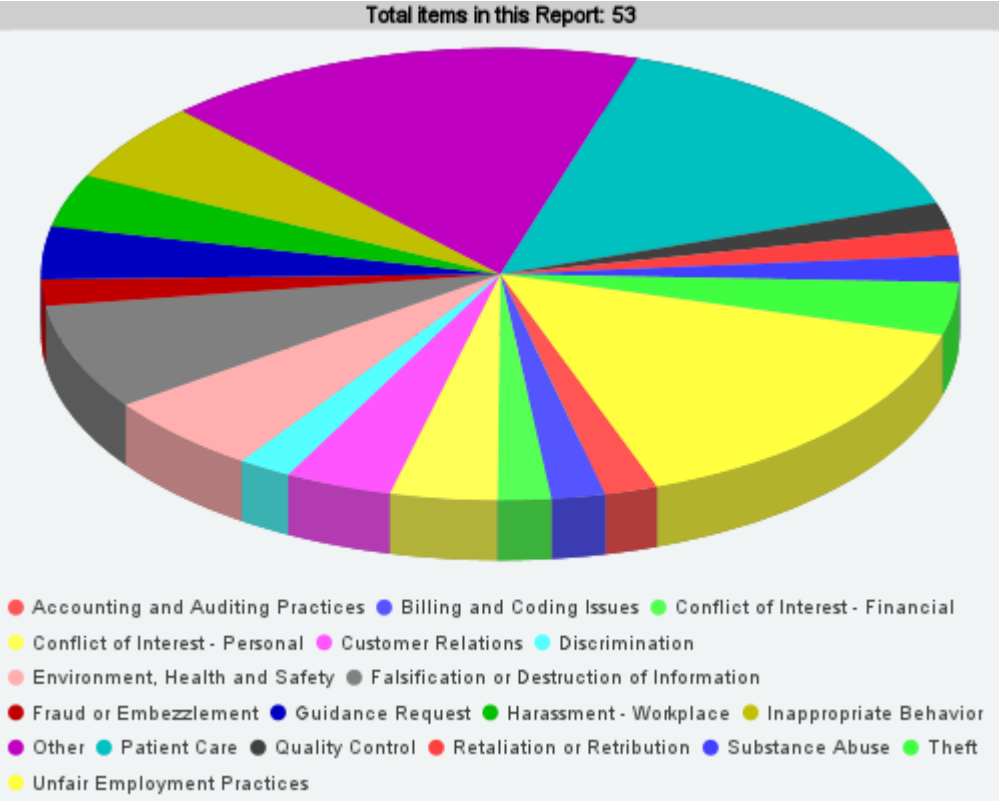
c. PRIMARY ALLEGATION SOURCE

SOURCE - CHART DATA	
	Frequency (Percentage)
E-Mail	4.0 (7.5 %)
Face to Face	3.0 (5.7 %)
Facsimile	1.0 (1.9 %)
Hotline	21.0 (39.6 %)
Mail	3.0 (5.7 %)
Referral from other HHC Office	4.0 (7.5 %)
Telephone	3.0 (5.7 %)
Web Submission	13.0 (24.5 %)
Website	1.0 (1.9 %)
Totals	53.0 (100%)



d. PRIMARY ALLEGATION TYPE

PRIMARY ALLEGATION TYPE - CHART DATA	
	Frequency (Percentage)
Accounting and Auditing Practices	1.0 (1.9 %)
Billing and Coding Issues	1.0 (1.9 %)
Conflict of Interest - Financial	1.0 (1.9 %)
Conflict of Interest - Personal	2.0 (3.8 %)
Customer Relations	2.0 (3.8 %)
Discrimination	1.0 (1.9 %)
Environment, Health and Safety	3.0 (5.7 %)
Falsification or Destruction of Information	4.0 (7.5 %)
Fraud or Embezzlement	1.0 (1.9 %)
Guidance Request	2.0 (3.8 %)
Harassment - Workplace	2.0 (3.8 %)
Inappropriate Behavior	3.0 (5.7 %)
Other	9.0 (17 %)
Patient Care	8.0 (15.1 %)
Quality Control	1.0 (1.9 %)
Retaliation or Retribution	1.0 (1.9 %)
Substance Abuse	1.0 (1.9 %)
Theft	2.0 (3.8 %)
Unfair Employment Practices	8.0 (15.1 %)
Totals	53.0 (100%)



IV. Status Update – OneCity Health

Independent Assessor Audit of OneCity Health

13) On December 3, 2019, the DSRIP Independent Assessor ("IA") began conducting its Year 4 Onsite Audit to determine whether OneCity Health correctly received DSRIP funds. To accomplish this objective, the IA reviewed OneCity Health's documentation to: (i) substantiate that it adequately supported DSRIP required activities and funding; (ii) determine that OneCity Health was in compliance with published DSRIP Program goals, requirements, and guidance; and (iii) determine the adequacy of OneCity Health's documentation previously submitted with the Quarterly Reports Review process. The areas under review included, but were not be limited to: (a) workforces spend; (b) DSRIP Partner funds flow distribution; and (c) patient engagement. A preliminary score card will be sent to OneCity Health

on February 28, 2020, and OneCity Health will have thirty (30) days to provide the IA with additional documentation, if necessary. A final score card will be released publically on May 31, 2020.

OneCity Health's Partner Compliance Attestation

14) 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."[3] To satisfy its compliance obligations as a PPS Lead, and to fulfill the requirements of the OMIG DSRIP compliance guidance, OneCity Health has developed a compliance attestation form, which is designed to assess its Partners' compliance with the program requirements.

15) 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, will distribute a Memorandum to OneCity Health Partners early this year, 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, is required to be completed by all OneCity Health Partners.

V. HIPAA Risk Analysis and Security Assessment

16) 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 on-site reviews at all of the System's acute care facilities, skilled nursing facilities, and Diagnostic and Treatment Centers, and a

[3] 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.

sample of the Gotham clinics. It also conducted virtual reviews of fourteen (14) other Gotham clinics.

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

18) Coalfire is finalizing its reports and a Risk Management Plan, which will identify the high and very high security risks to NYC Health + Hospitals. The Risk Management Plan will be shared with senior leadership to determine what treatment to give each of the risks (*e.g.* accept, mitigate, transfer, or share). Thereafter, the risks to be mitigated will be assigned to the appropriate individual or group to implement the mitigation plans, which will be tracked.