AUDIT COMMITTEE
MEETING AGENDA

February 11, 2016
12:30 P.M.

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

CALL TO ORDER — Ms. Emily A. Youssouf

- Adoption of Minutes December 1, 2015 — Ms. Emily A. Youssouf

ACTION ITEMS

- Resolution — Mr. Sal Guido

  Waiving under the Public Authorities Accountability Act (the "PAAA") any presumed conflict incident to the engagement of KPMG LLP to provide information technology consulting services while, at the same time, serving as the auditors of New York City Health and Hospitals Corporation ("NYC Health + Hospitals") auditors.

INFORMATION ITEMS

- Audits Update — Mr. Chris A. Telano
- Compliance Update — Mr. Wayne McNulty

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: December 1, 2015
TIME: 1:00 PM

COMMITTEE MEMBERS
Emily Youssouf, Chair
Josephine Bolus, RN

OTHER MEMBERS OF THE BOARD
Dr. Lilliam Barrios-Paoli

STAFF ATTENDEES
Antonio Martin, Executive Vice President/COO
Salvatore Russo, General Counsel, Legal Affairs
Deborah Cates, Chief of Staff, Chairman's Office
Patricia Lockhart, Secretary to the Corporation, Chairman's Office
Ross Wilson, Senior Vice President/Corporate Chief Medical Officer, Medical & Professional
PV Anantharam, Senior Vice President/Corporate Chief Financial Officer
Julian John, Corporate Comptroller
James Linhart, Deputy Corporate Comptroller
Lucinda Glover, Senior Director, Medical & Professional
Gassenia Guilford, Assistant Vice President, Finance
Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits
Wayne McNulty, Corporate Compliance Officer
Nelson Conde, Senior Director, Office of Professionals Services & Affiliations
Scott VanOrden, Assistant Vice President, Finance Central Office
Linda DeHart, Assistant Vice President, Finance Central Office
Alice Berkowitz, Assistant Director, Finance, Central Office
Daniel Lock, Director, EITS, Central Office
Devon Wilson, Senior Director, Office of Internal Audits
Chalice Averett, Director, Office of Internal Audits
Carol Parjohn, Director, Office of Internal Audits
Steve Van Schultz, Director, Office of Internal Audits
Carlotta Duran, Assistant Director, Office of Internal Audits
Delores Rahman, Audit Manager, Office of Internal Audits
Frank Zanghi, Audit Manager, Office of Internal Audits
Rosemarie Thomas, Audit Manager, Office of Internal Audits
Sonja Aborisade, Senior Auditor, Office of Internal Audits
Roger Novoa, Senior Auditor, Office of Internal Audits
Armel Sejour, Senior Auditor, Office of Internal Audits
Melissa Bernaudo, Senior Auditor, Office of Internal Audits
Sam Malla, Senior Auditor, Office of Internal Audits
Barbarah Gelin, Senior Auditor, Office of Internal Audits
Doriana Alikaj, Associate Staff Auditor, Office of Internal Audits
Nastasya Barnett, Staff Auditor, Office of Internal Audits
Erica Nairne-Hamilton, Staff Auditor, Office of Internal Audits
Jean Saint-Preux, Staff Auditor, Office of Internal Audits

Linda Maldonado, Staff Auditor, Office of Internal Audits
Sandy Bhigroog, Staff Auditor, Office of Internal Audits
Jay Weinman, Chief Financial Officer, NYC H + H/Bellevue
William Rodriguez, Associate Director NYC H + H/Bellevue
Seth Narine, Assistant Director, NYC H+ H/Bellevue
Caswell Samms, Chief Financial Officer, NYC H + H/Harlem
Ron Townes, Associate Director, NYC H + H/Kings
Kiho Park, Associate Executive Director, NYC H + H/Queens
Floyd Long, Associate Executive Director, NYC H + H/Carter/Coler
Vascenio Rhoden, Associate Executive Director, NYC H + H/Woodhull
Edie Coleman, Controller, NYC H + H/Metropolitan
Daniel Frimer, Controller, NYC H + H/Coney Island
Zoya Shapiro, Controller, NYC H + H/Coney Island

OTHER ATTENDEES
PAGNY: David N. Hoffman, Compliance Officer
KPMG: Jim Martell, Partner; Maria Tiso, Partner; Joe Bukzin, Senior Manager

DECEMBER 1, 2015
AUDIT COMMITTEE MEETING
MINUTES

A meeting of the Audit Committee was held on Tuesday, December 1, 2015. The meeting was called to order at 1:02 P.M. by Ms. Emily Youssouf, Audit Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee held on October 8, 2015 and an additional motion was made and seconded to hold an Executive Session of the Audit Committee.

Ms. Youssouf then turned the floor over to KPMG personnel and asked them to introduce themselves. Ms. Maria Tiso introduced herself as the Audit Partner and she introduced Joseph Bukzin, Senior Manager and Jim Martell, the Account Executive.

Ms. Tiso began with page one which is the opinion that summarizes that there were no significant deficiencies or material weaknesses in our observations. The observations in here are to improve the internal controls of the corporation.

Ms. Tiso continued by stating that the next page is a table of contents. The management letter is broken into six sections. There is a matrix of observations by network which we will go through. We have a corporate section, of which five of the comments relate to the corporate office. We will have some comments around information technology. We have comments over site visits that we did in early summer. We also have a section on the prior year's comments that have been cleared and remediated by the management team. Lastly, we have industry comments that are helpful to your governance committees and we have actually added them to a lot of our health systems. Mr. Martell and I will touch upon those as well. Page three and four is the matrix of observations. If you see the X you will see that most of the comments relate to corporate offices. There are two comments relating to Governeur and one to Woodhull and those two comments came from our site visits in June.

Ms. Tiso stated that she will turn the presentation over to Mr. Bukzin to go through the specific comments.

Mr. Bukzin saluted everyone and stated that the first comment on page five is the review of approval of consultant costs. This relates largely to the IT project related to the EMR implementation and really tightening up controls over approval and authorization and just good recordkeeping of consultant-related expenses. A lot of this was derived from our additional procedures that we performed, reviewing the OIG report, speaking with Mr. Telano and his team about his preliminary observations as well. In terms of the management response, they are actually working on automating and implementing some processes to remediate that matter. On the bottom of the page related to the financial statement preparation of the cash flows, that is one of the important elements of the financial statement and there are two versions. There is an indirect and a direct method cash flow statement. During the course of the audit we did work collaboratively with the management team. There were some changes to it and our recommendation is to enhance the review process and ensure that there is a due diligence review of the statement of preparation of the cash flow statement.

Bottom of page six, in terms of the affiliation contracts, this has been tailored down quite a bit to what it is been historically. This focuses on the status of the recalculations, which is a key component of the process in shoring up the expenses. Management has taken quite a jump from last year this time to this year through 2014. There has been a lot of progress made. There is still a little bit of catching up to do to in terms of getting through the 2015 recalculations.

Ms. Tiso mentioned that the comments that have an asterisk are comments that are repeats from last year. If you recall, there was a repeat comment relating to affiliations. Part of it has been remediated, and this is the piece that we felt needed to still have management's attention in the current year.

Mr. Bukzin continued with page seven. We have again another carry forward comment related to a sub ledger versus a general ledger reconciliation process. Management does have reports and controls to make sure there is appropriate capturing of expenses and accruals. But as a best practice if they could work with their IT department whether it's through a new system that may get implemented or if it's an ad hoc report that there should be some process put in place to reconcile a sub ledger to a general ledger for accounts payable.

Page eight, for a third party reimbursement estimates. As you may recall, we did have a corrected audit adjustment when we presented the results for about $20 million. This echoes that. That there was a control review that should be put in place to more formally document that evidence of review to ensure that there are not those kinds of things identified during the course of the audit process.

Page nine is the IT section of our observations. The first one relates to leading practices around passwords. There are several components of password best practices I'll say in terms of complexity, length, lockout attempts. This is again echoed in the management response that they would try to implement where possible. But again, that there are some system limitations with some of the applications that prevent them from doing it at this point in time.

Mrs. Bolus asked if the password should be eight characters? To which Ms. Tiso responded that what they are saying here is that best practice, what you see in the industry is the password should be eight characters versus six. They think there is some limitations with the systems that it has to be six. It is something that if your systems change, it would be something that you want to look at.

Mr. Bukzin continued with page eleven in terms of user access review. This revolves around two concepts; one is timely removal of terminated employees. When an employee is terminated there should be process and controls in place to ensure that all their access is remediated, I mean removed and disabled appropriately. The other recommendation here is to periodically review the user access rights and privileges of existing employees just to make sure that if job responsibilities and functions change that the rules associated with their level of access of particular systems mirrors that and is appropriate.

Page twelve is where we begin talking about some of the site visits. The first one is titled purchase order process. This was identified as a result of noticing that the purchase order was actually dated subsequent to the invoice date. Upon further review it was not that it was an unauthorized purchase, it was authorized. There were contracts in place, but it was more of a process of making sure if you are approaching the limit of a PO that someone is reviewing that limit. If it needs to be an addendum or modification to a limit, that there is a process there to make sure that is happening.

Page thirteen is where we pick up on the status of prior year comments that have been addressed. The first one relates to the financial reporting package that gets posted publicly on EMMA, an external website for others to view the financial statements. The recommendation last year was to just ensure that what gets posted is actually in fact the version of the financials that was reviewed and approved by the Finance Committee and management has put that process in place.

Page fourteen – accrued expenses. Last year there was something with the cutoff. About $8 million was identified from a cutoff perspective that management caught. So, the control and the observation here was let's take a closer

look at the accrual process more frequently than just at the end of the year and to implement a process perhaps on a quarterly basis, which they have done.

Page fifteen, as Ms. Tiso alluded to before, there were certain elements of affiliations observations that have been addressed during the year. The first one revolves around time studies for graduate medical education. Doing the internal audit review of PAGNY related expenses that did transpired. That did occur this past year, and we included I'll say a catch-all observation comment here that we recognize that the internal audit group is working closely on making sure that there are other things that are being remediated on a timely basis.

Ms. Youssouf stated that we appreciate that.

Mr. Bukzin stated that on page sixteen is capitalization of software costs. This was an accounting piece of the pie if you will. That if you are going through a construction project certain salaries and benefits as part of that should be recorded and capitalized on the balance sheet. Management did implement a process to do that appropriately this year.

Page seventeen account analysis received from other departments. The finance team often receives account analysis and documentation outside of their core group of individuals, and the recommendation here was to make sure there is thorough analytical review of what you are receiving from other departments. This did pop up again indirectly in our current year observation around reimbursement. This comment does acknowledge that there has been enhancements and improvements in policies and training and review but that there are still some refinements in the reimbursement area.

Page eighteen we had an observation around the benefits of centralization of certain functions, possible cost reduction, enhancing controls through centralization. We understand that this is something that is continuing to evolve as the organization itself continues to evolve with its 2020 Vision.

Page nineteen the vendor listing comment. This was a procedure that we had done for the '14 audit, a review of vendors on the master listing as compared to employees. There really should not be a master list identified as vendors. Management did implement a process to do that review throughout the year.

Page twenty for site visits to Goldwater. This is related to the closure of the Goldwater facility and tracking assets when you close a facility or even just asset tracking between the organizations. Management has implemented policies and procedures and training to make sure things are tagged and properly recorded and tracked in its asset system.

Page twenty-one custodial funds. In the '14 audit there was a change in accounting policy of how to handle custodial funds at Kings County. That was reverted and remediated back to the original policy that was handled by the Corporation.

Page twenty-two, the fixed assets. This was an isolated matter during the 2014 audit where there was an asset that was received and then removed because of Super Storm Sandy. The vendor actually retook possession of it. However, for accounting and bookkeeping purposes it did actually show up as a depreciable asset. So management has addressed that and they are actually using the asset.

Mr. Bukzin stated that that covers the current year and status of prior year observations. Ms. Tiso will go through the industry comments.

Ms. Tiso stated that there are about eight comments we consider industry comments. The first one talks about convergence and health care, and obviously it talks about the significant changes that are happening in the health care industry. The organization needs to continue to identify ways and initiatives to improve operating margin and to adjust to these changes. We know there is the 2020 Vision, this comment talks about what the organization is doing going forward to try to sustain all these changes.

Page twenty-five talks about the New York State Delivery System Reform Incentive Payment (DSRIP). We all know this is the hot topic these days. It is obviously a five-year DSRIP period beginning April 1, 2015. HHC is the lead participating provider. This comment talks about a lot of the risks that are going forward. You are going to have a lot of these participating providers that you will be dealing with and really talking about making sure that you continue having a good governance structure, a good financial reporting mechanism, ensuring that the reporting is accurate since going forward there is going to be metrics and other areas that you are going to need to opine upon. Again, making sure a lot of these areas are addressed going forward.

Mr. Martell stated that when you think about convergence in DSRIP you think about 2020 Vision. The medical industry has changed. We have seen it change and it is going to change even more relatively quick. People are going to be serviced and the medical services will be more out-patient. Ambulatory care, you are controlling the dollars for all services, you have a managed care company that has already accepted risk in some form or fashion.

In some cases you are ahead of some of the other organizations. However, as you go forward for the next three to five years it is going to change quickly. Telemedicine is going become real hot. It is going to be, how do I control the patients and the dollars and the services that we provide and other organizations provide. You are going to have the medical side of the business but then you're going to have what I will call the infrastructure. How do you manage the provision of those medical services?

All this comes together and your corporate finance team, your operational team, the skill sets are going to be different. The requirements to implement 2020 today, I make you a bet 50 percent of what the plan is today, when you get halfway through you will change because you will have updated information and it will be a continuing process. So that is what convergence is. It's already started with DSRIP and already started with the population health medical service aspect. This to me is the biggest thing that will affect HHC going forward. How well do you perform and how well can you monitor costs and maximize revenues.

Ms. Youssouf asked when you said about the telemedicine, have you actually seen that -- you see little spurts and information about it but have you seen it practically being used? Mr. Martell answered that he has seen two health systems who have actually opened up I would call them clinical sites and things of that nature where there is a physician assistant at the location and the physician is somewhere else and they do everything over the computers with visuals obviously.

Mr. Martin said that he does not want to give the impression that we are not doing it. We are doing it, we just are not as far along as I think we would like to be. But certainly, particularly for our chronic disease patients, we are very much into it.

Mr. Martell commented that staying with that is part of the vision. As you move forward you walk, you run, you go backwards. I have one client that has a similar vision, they also call it 2020. Their view was that by the year 2020 they will have 60 percent of their operating revenue stream on the ambulatory care and on the outpatient side. They are a $5 billion revenue stream organization, eleven hospitals. Their view is what we call the bricks and mortars are

ultimately going to come down in some form or fashion. Your vision is not wrong, it is how you compete and continue to progress with the other health systems around.

Mr. Martin stated that he thinks that is Dr. Raju's vision and that is why he structured us in the way he has with the service lines and CEOs and the facilities so that we can be nimble. That we really react very quickly to these changing times.

Ms. Youssouf stated that she agrees because when you look at the convergent points in your letter it sounds like it is a grand slam. Thankfully we have great leadership that is on the same path and it is just being able to get there.

Ms. Tiso continued with page twenty-seven. We have a comment about cyber security. I am sure everybody here hears about cyber security continuously. So, cyber security is not just a significant risk to health care organizations but it affects every single organization. People say is it going to affect my organization? The question is when is it going to happen? So, it's something serious that the organization – I know it's a significant risk to HHC but to continue to make sure you have policies and update policies as you move along.

Mr. Martell added that the key thing is not if it's going to happen, when it's going to happen and what process you have in place to remediate and deal with that because it's going to happen good, bad or indifferent. If you go back, when we talk about our top ten Audit Committee issues in the beginning of every year, this was on the list but this was very low. It was like seven or eight. I would argue to say that if KPMG came out with the revisit of the top ten this would be in the top three just because of all the breaches we have seen. Not only in the health care but in others. Unfortunately you got a lot of people who are looking for the information you have which is very, very valuable.

Ms. Tiso continued with the next comment – data analytics. This is another hot topic. This also tends to dive into the 2020 Vision. You're getting all of this data. How are you going to improve patient satisfaction? Improve the patient's experience? Once you get that data what are you going to do with it? How do you measure it? How are you going to address data analytics going forward? Again, it's part of this whole 2020 Vision.

Mr. Anantharam asked what the star referred to. Ms. Tiso responded that anything that had a star was a comment that we also included in the prior year.

Mr. Martell stated that as part of our top ten items for audit committees is to at least understand, read, and know about, this has not changed from prior years. Data analytics was identified last year and it's identified this year.

Ms. Tiso continued with page twenty-nine – disaster readiness. We all know that disaster response and recovery is also a significant risk to every organization. Again, just making sure that the organization educates their personnel and that they have policies and procedures around disaster readiness.

Page thirty – privacy. Making sure you continue to monitor compliance with the new privacy, security and breach notification rules under the HIPAA and high tech rules. Those are still continuing to evolve. Making sure you have policies and procedures that you are monitoring compliance.

The last comment on page thirty-two talks about the electronic personal health information. Obviously mobile devices are being use by physicians. How is the organization making sure that patient information is being protected? What policies and procedures do you have in place to make sure that all the PHI information is secured?

Ms. Tiso stated that that completes their presentation on the management letter. Again, none of these comments are a significant deficiency or material weakness but observations that would improve the operations of the entity.

Ms. Youssouf thanked them for their hard work on this and for a very thorough and very helpful explanation in this meeting. We are recommending this letter and hopefully next year those comments will all be addressed. She then turned the meeting to internal audits for an update.

Mr. Telano saluted everyone and stated that the audits to be discussed at this meeting are the ones conducted of the six NYU affiliation facilities. The audits will be discussed at one time due to the minimal number of issues noted at each site. Although the affiliates and corresponding facilities are operating at an efficient level, there are a few areas in which internal controls need improvement. One of the most common issues that we find during the course of all our audits is system access. And once again, terminated employees at all six locations still had access to either our operating systems or they had active identification badges. Usually we are finding that it is due to lack of communication and timely communication starting from the departments that are supposed to send notice to the human resources department which then forwards it to the IT department and then they go forward with that. It is something that is corporate-wide that we have been addressing.

Dr. Barrios-Paoli stated that it is not a difficult thing to resolve. It seems to me when someone is terminated at that point in time you collect their stuff. That is how it is done in every other agency in the city.

Mr. Martin stated that there was an operating procedure that was developed that said exactly what you said. That once an employee is let go HR takes the information and they notify IT and they deactivate them from the system. It just has not worked – I am at a loss. This keeps coming up audit after audit.

Dr. Barrios-Paoli asked if we could develop it from ascension to the deactivation? To which Mr. Martin responded that it is not just the affiliations.

Mr. Telano said that it is very difficult to hone in on who is responsible. These particular audits, Woodhull, Cumberland and Coler/Carter, we were able to determine that the NYU Human Resources Department were delayed in notifying the appropriate individuals. But on most of our audits we cannot isolate it as to who is responsible because many parties are involved.

Ms. Youssouf asked if there is any way to cut down the number of parties involved. Mr. Martin responded that he is going to commit to visit this because this is very distressing. This has been a year and it keeps coming up.

Dr. Barrios-Paoli added if somebody really wanted to commit some mischief they can.

Mr. Martin said that that is the issue. That they still have access when they should not. If you would give me to the next audit committee meeting, I can come back with an updated plan.

Mr. Telano continued with page five of the briefing, comment B, quarterly reports of the Roster were not being submitted to the Office of Professional Services and Affiliations timely and the feedback was that this is an unrealistic expectation and that the contract, when they are renewed, should be changed to address this to a more realistic commant.

Ms. Youssouf asked if this is normal in all of our contracts? Mr. Telano answered yes. It seems to be very delayed throughout the various affiliations. It is not limited to NYU, we have found this issue at all the affiliations.

Mr. Martin commented that he believes the data that you need to make the reconciliation really comes in at around three months. I believe all the parties need more time. I do believe in the current affiliation agreement we are making it a six-month period so that we can actually have adequate time to actually do the work that needs to be done.

Ms. Youssouf asked if this is for the Roster Contract Service Provider. Mr. Telano responded that this is the listing of the Roster – individuals that are on the roster.

Ms. Youssouf then asked if they really need six months to figure out who is working. Mr. Telano answered that there is a lot of activity and turnover.

Mr. Conde, Senior Director for affiliations answered that with regards to the roster, the roster comes to us annually and quarterly. In terms of getting quarterly updates some facilities are better than others in giving us the data. Going forward we are looking at changing the time due to 60 days instead of the current 45 days.

Dr. Barrios-Paoli asked are any of these things automated and why is it difficult to get timely information? Mr. Conde responded that it is a process that data comes from the affiliate to the facility to us. We are all working with one of our affiliates with a shared database that facilitates the information of that data and we are working with other affiliates to see where we can implement that shared database methodology to all of our affiliates at this point in time. We expect that once that is in place it will facilitate us accessing information at any point in time

Ms. Youssouf commented that it seems like a relatively easy fix for something that we should be on top of, right?

Mr. Telano continued and said moving on to comment C, at Woodhull/Cumberland the background check for numerous subcontracted residents could not be verified. The feedback on that was from the HHC credentialing office that they did not keep copies on file and they assured us that it was conducted and they believe they sent the paperwork to the affiliation but that could not be confirmed. So they will look to get the information.

Ms. Youssouf asked that you are saying that the HHC credentialing office at the facilities do not keep copies? To which Mr. Telano responded yes, this is at Woodhull, for these individuals they did not have copies. They believe they forwarded them to the affiliation.

Ms. Youssouf then asked isn't it on the computer? Mr. Telano answered that these are subcontractors, it is a little more unique than residents that are provided directly by the affiliations.

Mr. Martin asked if a Woodhull representative were present.

Ms. Chairmain Cross, Director of the Graduate Medical Education Department, stated that first I would like to thank the Audit Committee for their recommendation. Specifically to your question, we do have affiliated residents rotating at Woodhull Hospital. The way business was conducted during that time, we had certain must-haves in terms of credential process, which is employee health clearance, flu vaccination. Background was noted where it is conducted by the sponsored paid institution. We were not receiving a copy from the facility such as SUNY or NYU. We had a verbal agreement that it was done because it is a requirement of the residency program. But we did not accept a written copy. Thus, when the audit was conducted, it was not in the resident's file at the time. But we took corrective action immediately and moving forward we did a retro-review starting July 1, 2015 and we now are requesting it and it is in the resident's file.

Ms. Youssouf said thank you very much. That's a happy ending.

Mr. Telano said moving on, one last issue was at Coler/Carter. We had looked at 17 subcontractors throughout the six NYU facilities and we found that there was only one in which they did not provide time sheets. This is in contrast to the other affiliations in which this was a very common finding. But there was only one issue that they were being paid without the documentation.

Mrs. Bolus stated that is says $10,000 each month. How much is that? Mr. Telano said 12 months.

Mrs. Bolus said that that is a big amount.

Ms. Youssouf asked if that's been fixed as well. Mr. Telano responded yes.

Mrs. Bolus asked how was it addressed? We got the paperwork or the money back? Mr. Telano stated that will be utilizing paperwork.

Ms. Youssouf asked if they guaranteed the work was done at the facility? Mr. Telano answered yes, they feel comfortable.

Mr. Martin asked if the work was done? For the record the work was done.

Mr. Telano stated that that concludes his presentation.

Ms. Youssouf turned the meeting over to Mr. McNulty.

Mr. McNulty introduced himself as Wayne McNulty, Chief Corporate Compliance Officer and Senior Assistant Vice President ("CCO") and requested that the Audit Committee (the "Committee") turn to page three of the Corporate Compliance Report (the "Report") - - Record Management. He proceeded to provide the Committee with a year-end update. Mr. McNulty stated that New York City Health + Hospitals operates and maintains the corporate-wide record management program as governed by operating procedure 120-19 Corporate Record Management Program and Corporate Record Retention and Disposal.

Mr. McNulty explained to the Committee that there were three goals of the record management program: (i) to maintain records generated and kept by NYC Health + Hospitals in the normal course of business in a manner consistent with federal and state law; (ii) to assess the value of any record prior to determining its disposition; and (iii) to encourage the systematic disposal of unneeded records. He stated that NYC Health + Hospitals currently has numerous records that are stored not only on-site but offsite with a third-party vendor. He proceeded to paragraph two on page three of the Report, where he highlighted that NYC Health + Hospitals currently stores 569,000 boxes or records at third-party vendor Recall at a cost of $310,000 a month. Providing a summary from the Report, he stated that the top facilities with the number of boxes is Kings with 67,000 boxes, Woodhull with 63,000 boxes, and Bellevue with 51,000 boxes.

Mr. McNulty requested that the Committee turn to paragraph nine on page five of the Report. He then continued with a discussion about a fire that occurred at the beginning of this year involving Recall/City Storage. He stated that on January 31, 2015 a fire destroyed the Recall facility located in Brooklyn. He explained that two buildings were involved, noting that there was a north tower and that the north tower was heavily destroyed. He told the committee that NYC Health + Hospitals, along with the records of other agencies statewide and City, and records of companies, were destroyed. In summary, he advised the Committee that page seven, paragraph 13, of the Report consisted of a

breakdown by facility, central office, and MetroPlus of the different 144,000 boxes of NYC health + Hospitals records that were destroyed.

Mr. McNulty requested that the Committee turn to page eight, paragraph 14, of the Report, where he discussed NYC Health + Hospitals long term record management plans going forward. In summary, he informed the Committee that a record retention counsel ("RRC") chaired by the CCO and the acting Chief Information Officer ("CIO") was instituted. He stated that the RRC consists of members from legal affairs, the different divisions of central office, and each facility throughout the Corporation. He advised the Committee that the purpose of the RRC is to discuss different areas of record retention law and to develop practices and policies system-wide that are consistent.

In summary, he informed the Committee that he was going to introduce a proposal to the RRC in December that called for the NYC Health + Hospitals to: (i) purchase a record management system that will help inventory and categorize NYC Health + Hospitals records corporate-wide; (ii) procure a system that will help NYC Health + Hospitals meet its State regulatory requirements. He stated, in pertinent part, that he would have a discussion about this matter with the acting CIO and the same would be discussed, as required by law, with the RRC and the recommendations the RRC would be followed.

Ms. Youssouf asked if he has any idea how much would something like that cost?

Mr. McNulty responded that his research showed between $100,000 and $200,000. He stated that there were grants that NYC Health + Hospitals may be able to apply for through the Department of Education.

Ms. Youssouf stated that I think it might be good if you just took a moment to refresh everyone's memory why we have so many boxes, what the requirements are.

Mr. McNulty stated, in sum and substance, that under the State's Arts and Cultural Affairs Law and its implementing Department of Education regulations, NYC Health + Hospitals, as a public benefit corporation, is required to maintain records in accordance to a schedule promulgated by the Commissioner of the Department of Education. Mr. McNulty explained that, the schedule contains numerous categories from employee health records to medical records to the records of the instant Audit Committee meeting. Mr. McNulty further explained that any record created by NYC Health + Hospitals in the normal course of business must be maintained for a specific period of time outlined in the schedule.

Mr. McNulty continued by explaining that NYC Health + Hospitals follows the schedule that the State put together and said schedule was adopted by the Audit Committee in June of 2014 and the full board in June of 2014. He commented that the operating procedure is 288 pages long and covers all of the different record retention requirements that NYC Health + Hospitals has. For example, he explained, patient records under the Education Law and under CMS regulations and DOH regulations must be maintained for seven years. He further explained that, if the record involved a minor, NYC Health + Hospitals would have to maintain the same for 22 years. However, he added in summary, pursuant to the False Claims Act, any record, including patient records, utilized by NYC Health + Hospitals to submit a claim to be reimbursed for Medicaid and Medicare must be maintained for at least ten years. He stated, in pertinent part, that employee health records have to be maintained for 30 years after the corresponding employee dies - - thirty years after death, which Mr. McNulty stated means we have to keep the records forever basically.

The schedule differs based on the type of laboratory tests. Certain laboratory tests you may have to keep for 10 years. Certain laboratory tests you have to keep for 30 years. We took the schedule and arranged it into different categories. If you looked at our operating procedure and you wanted to know how long to keep an employee record you would see

it broken down in a particular area. The same thing for health records. The same thing for research related records and the same thing for administrative records, which we broke those particular categories down.

Some options are in the future going forward. It is to digitize records when they no longer need it for immediate use but have not met the period of retention. We will discuss that also at the RRC. We will also look at whether or not we can go back and digitize some of the records stored. However, that will probably be more costly than where the records are at.

Ms. Youssouf asked if there is a point in time where there is a plan to digitize all of this?

Mr. Sal Guido, Interim Corporate Information Officer, said that from a digitalization of the records, all of our records from our standpoint or a patient standpoint are already digitized. They have been digitized for about 20 years. Some of the other things that Mr. McNulty had alluded to was some of the paper that we have around. With the introduction of the EMR system a lot of that paper will automatically be digitized as well. As we roll out the EMR a large percentage of that paperwork that we currently have in these boxes will be digitized and catalogued so that we can retrieve those when required.

Going forward, we actually priced out digitizing the paperwork that we have. It is about a penny, a penny and a half per page. Think about how many pages are in each one of those boxes and how many boxes. It is a massive undertaking to do. And again, to categorize the paperwork in the different categories that Mr. McNulty had talked about, you know, what is for an employee medical record, 30 years, we have to put that to the side and so on and so forth. Just sorting that out would probably take us a year or two. We have been working very closely with Mr. McNulty and his office on coming up with the best strategies moving forward.

Mr. Russo stated that it is a Herculean task, and above and beyond that, these schedules were not intended really for hospitals. They are for state agencies. The categories do not say medical record. They list components that you have different time frames, it is very complicated. I applaud Mr. McNulty and Mr. Guido for tackling this in the way they have.

Dr. Barrios-Paoli asked if there is any way of negotiating that different standards be applied for hospitals?

Ms. Youssouf commented that it would take legislative action to change.

Mr. McNulty stated that it would take legislative action to change some of the standards. Some of the laboratory standards and some of the employee standards, he explained, are copied from OSHA, from the federal regulations. They also require the City of New York to create a schedule, so the City of New York has a schedule that is just as comprehensive as all these state agencies. Any public authority basically has to have a record retention schedule.

Ms. Barrios-Paoli asked if they all agree with each other?

Mr. McNulty said they are very close to each other. There are fine nuances. One is six years, another seven years he added. But nothing that would be substantial that would affect our program he commented. In summary, Mr. McNulty stated as an example that the requirement to keep employee records for 30 years after death is an actual federal requirement. He elaborated further that this was Occupational Safety Health Act requirement and that the Department of Education just copied that particular requirement.

Mr. Martin said that I am going to be a little provocative here Sal, but why couldn't we challenge it? And why couldn't we at least be asked to be held to the same standard as the not-for-profit hospitals? Because from what I understand the not-for-profit hospitals aren't held to as strict a standard as we are.

Ms. Youssouf asked if their standard is determined by whom?

Mr. McNulty responded that by different regulations, the CMS regulations, the False Claims Act Statute and so forth. For example, Mr. McNulty stated, retention of emails - - if you are a not-for-profit hospital that is not a government hospital, you just have to retain emails based on your legitimate business purpose. Where NYC Health + Hospitals, he added, has to retain emails based on all of these particular categories, which makes it very difficult he commented.

Ms. Youssouf stated that she is not as worried about emails. Mr. McNulty added that the point he was making was the State requires NYC Health + Hospitals to take each email and put it into one of those categories. We may have to save an email for seven or ten years he stated. He continued by stating that, if you are Columbian Presbyterian you can get rid of that email in 30 days if you want.

Mrs. Bolus asked that if it's somebody's job to look at every email and decide which category it is?

Mr. Guido replied that we can automate the process. When you say we shouldn't worry about emails, we have emails for 25 years.

Ms. Youssouf stated that it is controversial. So, I think it is a great idea. We talked about this in the pre-committee and everybody said we could not do it. But I think if we can do it. We should try.

Mr. Russo added that legal action would not be something we could do, but a legislative action would be the area that can be done. There is also, as Mr. McNulty is well aware, you can seek to have waivers of certain parts but they are only good for a year and you have to do them every year. But I think a legislative attack would be something that's better. The public benefit corporations such as the public hospitals that are in Nassau, Westchester, all of them would be under the same regulations. Maybe we can get them together. We should try to get LaRay Brown while she's still here to work on that.

Ms. Youssouf said that that is a great idea if they're all under the same.

Dr. Barrios-Paoli suggested that we should also talk to the city legislative people. There is a health committee person that probably would be helpful to us in Albany.

Mr. Russo stated that there will still be a number of records that have to be kept. Thank you. We will follow-up. Mr. McNulty you will spearhead that.

Mr. McNulty added that the Department of Education coincidentally contacted him last week and they want him to sit on their state-wide committee with respect to the recommendations of the schedules. He stated he would address this matter then.

Mr. McNulty continued on to page ten of the report and discussed the ongoing monitoring of excluded providers. He informed the Committee that since the last time the Committee convened, there were no reports of excluded providers with regard to the NYC Health + Hospitals acute care, long-term care and ambulatory care sites. He stated that there was one excluded provider with regard to a possible DSRIP partner. He explained that it involved two physicians in an

Article 28 health clinic. The two physicians were under a 199 count indictment handed down by the Kings County grand jury. They were excluded from the program he explained. He stated that the Article 28 has since been put back into the Medicaid program and no longer are excluded.

I confirmed with the executive director of One City Health, which is our wholly-own subsidiary that handles DSRIP, Dr. Jenkins, and she confirmed that no DSRIP payments were made to the excluded physicians or the Article 28 health clinic. I will be working closely with Dr. Jenkins and legal affairs as we go forward with regard to any contracting matters pertaining to that particular health clinic. We are currently reviewing all H+H employees who provide prison health services as it relates to exclusion checks.

Mr. McNulty moved along to section three of the Report - - the staffing plan. He advised the Committee that NYC President and CEO Dr. Raju was presented with the OCC's staffing plan for calendar year '16. He informed the Committee that every year pursuant to Operating Procedure 50-1 Corporate Compliance Program a new staffing plan is presented. This year, he stated, the focus is to move forward with the Corporation's vision and focus on long-term care and ambulatory care compliance activities. Therefore, he explained, the OCC was undergoing restructuring to focus on those particular areas. With regard to the acute care facilities, he added, the focus would be on a regional basis. He elaborated, in sum and substance, that compliance officers would be dedicated to: (i) Bronx facilities, Brooklyn facilities, Queens facilities and the Manhattan acute care facilities: (ii) long-term care facilities; and (iii) the ambulatory care sites. He explained a .4-FTE for the Gotham Health FQHC and a .4-FTE for the HHC ACO were being created as part of the plan, as well as a 1-FTE for the DSRIP compliance. He stated that the DSRIP compliance position is posted has been posted and we have engaged in the recruitment process for that particular compliance officer.

Moving forward to the National Government Services Reviews. NGS is a Medicare contractor and they look at our claims that are submitted. There have been several recent claims that have been denied in particular categories. I am looking at that very closely with revenue management and we will have a report at the next Audit Committee as to the detail of these particular denials.

Mr. McNulty moved onto o the HHC, ACO Inc. As previously discussed with the Audit Committee in June of 2015, he stated, HHC ACO is a wholly-own subsidiary that was selected by CMS to participate in the Medicare Shared Savings Program. It's a three-year term that began on January 1, 2013. Under the MSP, the ACO is accountable for improvement and quality of care for approximately 13,000 Medicare fee for service beneficiaries who received primary care at NYC Health + Hospitals.

If you would kindly turn to paragraph three on page twelve. Under the Affordable Care Act, the ACOs are groups of providers and suppliers of services and hospitals, physicians and others involved in patient care that agree to work together to coordinate care for the Medicare fee-for-service patients. The goal of ACO is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

If you would turn to page thirteen paragraph five. There are four different key categories or quality performance standards in four different categories that the ACO must satisfy to earn savings. It is patient caregiver experience. There are seven measures in that category. Care coordination and patient safety. There are six measures. At risk population there are five measures and two composites consisting of an additional seven measures. Preventive care there are eight measures. In paragraph seven, in October the Office of Corporate Compliance ("OCC") and HHC ACO senior management received a warning letter from CMS stating that the HHC ACO didn't meet certain of its performance standards in one of the categories that I mentioned above.

On page fourteen paragraph nine, it's some more detail. Three of the quality measures that HHC failed to meet were in the care coordination patient safety domain. Specifically ambulatory care sensitive admissions for COPD. Ambulatory care sensitive admissions for heart failure. A percent of primary care physicians who qualify for the Electronic Health Records Incentive Payment Program. Which is usually referred to as meaningful use. CMS is requiring HHC ACO to have a corrective action plan. Particularly that it should institute policies and process changes to prevent failures to new performance standards going forward and that they review, the CMS ACO spotlight for information regarding ACO trainings.

Mr. McNulty asked for the representatives from the HHC ACO present and IT present to approach the table so they can discuss going forward how we will address the performance considerations and the meaningful use incentive program.

Mr. Russo asked them to identify themselves. They did as following: Ross Wilson, Chief Executive of the HHC ACO and Mr. Sal Guido, Interim Corporate Information Officer.

Dr. Wilson stated that first, to link this discussion with the management letter conversation, there are two things that have just occurred here that you heard from the previous presenters. One is the issue of data analytics. The other one is the issue of population health. The ACO is one of the mechanisms that we are using to bring those so-called convergence issues together. We have been successful in hitting the quality targets in aggregate and saving money for two consecutive years. We are the only public ACO in the whole country that has achieved that and only one of 14 percent of all ACOs that have achieved that. So this is a success.

The warning letter has occurred because CMS has now moved its view from just the aggregated quality score, where we were at the 76 percentile across the country. It is great to be in the top quarter of performance for our patients. But not only do we have to get the aggregate score we actually have to get the sub scores in each area. So the rules changed a little bit. So, in one of the sub scores, in the care coordination domain, they put the meaningful use physician at a station indicator. It is not really a quality indicator, it is a measure of whether our physicians separately from whether we as a corporation have gone through the meaningful use requirements and provided those requirements, this is an attestation from physicians that they have attested that to meaningful use in their own practice. CMS changed the rules on how the scoring works in this area. We are not as far developed as we have been at the corporate level. I might ask Mr. Guido to fill in the details about where we're up to.

Ms. Youssouf asked when did they change the rules? Dr. Wilson responded that they amended the measurement rules between year one and year two of the three year MMSP. They did not change the indicator, they changed how it was required to be scored. Initially the requirement was you got the aggregate score. Now you have to have the aggregate score but you also have to have essential sub scores as well.

Ms. Youssouf asked how long ago? Was it a year ago? Dr. Wilson answered months. The reason this is a warning letter is because they just changed the rules and they then responded to our last set of results. They are not excluding us or penalizing us. At the same time we got the warning letter we also got the funds distribution for doing well. We got the good news story as well, and this is like a heads-up to say we have changed the rules and in the next 12 months you are going to have to get it right.

Mr. Guido stated that because of the rule changes we had some prerequisites that had to be put in place in order to meet the meaningful use to eligible provider requirements. Those prerequisites one was the e-prescribe which we had to put in place, and the second was to upgrade our existing EMR system to what they call a certified MU-2 quality

operating system. Meaning we had to upgrade QuadraMed in order to be certified under the new rules. We have achieved both. We have rolled out the e-prescribe and we have met the requirements from an e-prescribe standpoint. We also rolled out to all of our eight QuadraMed instances the new upgrade to satisfy that requirement. We will attest to MU-2 eligible provider October through December and will report out to CMS in January. We are on track and no problems to report at this time.

Dr. Wilson added that in summary on this issue, this is a direction we were going. There are some structural reasons why we were a little bit behind. The plan is in place, the solution is identified and occurring and we don't envision this will be a problem in the subsequent years.

Mr. McNulty said that I will be following up with the Office of Legal Affairs just to determine if there are any potential overpayment issues here which at this juncture appears to be highly unlikely. And I will be working closely with the HHC ACO to look at all the performance indicators to ensure going forward that all the mitigation plans are implemented.

Mr. McNulty continued with page seventeen of the Report - - the privacy incidents and related reports for the third quarter of calendar year 2015, which is July 1st to September 30th. Mr. McNulty stated that during the third quarter there were 21 complaints entered into the ID Experts HIPAA tracking system. Mr. McNulty gave the following summary of the 21 complaints received:

- Seven were found to be violations of NYC Health + Hospitals HIPAA privacy operating procedures.
- Three were determined to be unsubstantiated,
- Five were found not to be a violation of NYC Health + Hospitals policies and procedures; and
- Six are still under investigation.

Mr. McNulty informed the Committee that, with regard to the seven violations of NYC Health + Hospitals policies and procedures, it was determined that all seven were breaches of protected health information. Mr. McNulty moved on to page eighteen, paragraph six and provided an overview of the seven breaches. He informed the Committee that the majority of the breaches involved records that were sent to the wrong patient from NYC Health + Hospitals' HIM departments. He moved to page 19 of the Report and discussed two breaches that he described as significant.

He stated that one of the breaches occurred at Woodhull Hospital where a laptop that was connected to an electromyogram machine was stolen from the patient examination room within the hospital. In summary, he explained that, although the laptop was secured to the machine with a wire, the wire was cut and the laptop was stolen. He stated that the laptop was password protected but it was not encrypted. He explained, in sum and substance, that because the laptop was not encrypted, the theft of the same amounted to a breach of the protected health information and notification to 1,581 patients was sent.

The second breach, he described, occurred at Lincoln Medical and Mental Health Center. He stated this incident consisted of disclosure of protected health information for 48 patients who were treated at Lincoln. He advised the Committee that one of the physicians there improperly used the protected health information to conduct an unauthorized research project which the physician transmitted the protected health information of the patients to a private lab in Torrey, Pennsylvania.

Mr. McNulty continued his Report by turning to page 20 - - the Office of Civil Rights of the Department of Health and Human Services ("OCR"). He stated that OCR investigates and enforce the HIPAA rules and regulations. In summary,

he informed the Committee that OCR contacted NYC Health + Hospitals with regard to a breach that occurred at Metropolitan Hospital in September 2015, where through NYC Health + Hospitals' Data Loss Prevention Program, it was discovered that a Metropolitan employee was sending emails with protected health information to his personal email account at a second employer. Mr. McNulty stated that the employee was at the second employer when he was supposed to be at NYC Health + Hospitals and was subsequently terminated. Mr. McNulty advised that a breach notification letter was sent to affected individuals in June of 2015. Mr. McNulty continued and, in summary, informed the Committee that the other two inquiries that OCR made involved the following past breaches that were previously reported to the Committee:

- At Bellevue Hospital Center there was a breach involved with an employee who sent an email spreadsheet with PHI to her brother to assist her with her Excel spreadsheet. As a result, 3, 700 affected patients were sent notification letters. The employee received disciplinary action.

- At Jacobi Medical Center there was an employee who was voluntarily separated from services and then six days later went into her account, which was not turned off, and she accessed the protected health information of over 90,000 patients. This led to NYC Health + Hospitals pending over $220,000 to send out breach notifications and providing credit monitoring to those affected patients.

Ms. Youssouf asked if he knew why she did that. Mr. McNulty answered that she said she wanted to have access to the information in case she was asked questions after she left NYC Health + Hospitals.

Mr. Martin added that she left and went to work for the Department of Health and she transferred that information. I think she felt she could utilize the information. This is very complicated, she is still within city government.

Mr. McNulty moved on to Section VII of the Report - - the compliance report for the third quarter of calendar year 2015. Mr. McNulty stated that 74 compliance-based reports were received. He commented that none of these Reports were deemed to be priority A. He continued and provided that there were 18 priority B and 56 priority C reports. Priority A reports, he explained, require immediate attention and involve a compromise of patient or employee safety. He informed the Audit Committee, in summary, that the instant report was the first quarterly report that did not include a Priority A report.

Mr. McNulty moved along to paragraphs two and three on page 21 going on to page 22 of the Report – which he stated was: (i) the breakdown of different classes of reports and whether the reports received came through the confidential helpline, mail or email; and (ii) the different types of reports. In summary, he informed the Committee that the OCC was working with its vendor to change the different analysis of reports and provide reports with greater details.

Mr. McNulty turned to section VIII on page twenty-two of the Report -- Update on DSRIP compliance activities. In general, Mr. McNulty reminded the Audit Committee that the recruitment process for a DSRIP compliance officer had commenced. He stated that, once hired, this individual will be solely responsible for DSRIP related compliance, privacy and record management activities and initiatives. He also provided that the expansion of the compliance helpline to accommodate DSRIP related compliance complaints, queries and other reports was being worked on.

Mr. McNulty turned to Section IX of the Report, compliance with the Public Authorities Accountability Act of 2005 and Reform Act of 2009. He informed the Committee that, with the assistance of the Office of Legal Affairs, an assessment of NYC Health + Hospitals compliance with PAAA compliance was being undertaken.

Ms. Youssouf asked does that mean that we were not in compliance? To which Mr. McNulty responded no, we are just doing an assessment to ensure the Corporation is in compliance and also looking at every subsidiary. The rules for the subsidiaries, he stated, are different than the rules for the Corporation. He pointed out that an assessment of the Corporation was performed in the past and stated, in summary, that NYC Health + Hospitals was in good shape.

Turning to page twenty-three section X -- fiscal year '16 ("FY2016") Corporate Compliance Work Plan Status Update. In summary, he informed the Committee that a draft confidential corporate compliance work plan was developed, which, he stated, was scheduled to be submitted to the Office of Legal Affairs' outside counsel Katten, Muchin, Rosenman for review early next week. He explained that, once reviewed as to acceptability as to legal form by Katten the work plan will be finalized and submitted to NYC Health + Hospitals president, CEO Dr. Raju in December 2015. The work plan will absolutely be finalized in December because it has to be finalized before Dr. Raju can certify to Medicaid in December that we have an effective compliance program which occurs every December at the end of the calendar year.

Mr. Russo added that Legal Affairs has worked with Mr. McNulty's office in developing the work plan, but it was a recommendation by our outside auditors that outside counsel also take a look at that. That's why Katten is looking at that.

Mr. McNulty stated that if there are no further questions that concludes my report.

Ms. Youssouf thanked him then stated that they are going into executive session.

Ms. Youssouf said that they are back from the executive session; they discussed matters of potential litigation.

There being no further business, the meeting was adjourned at 2:40 P.M.

Submitted by,
Emily Youssouf
Audit Committee Chair

RESOLUTION
AUDIT COMMITTEE

Waiving under the Public Authorities Accountability Act (the "PAAA") any presumed conflict incident to the engagement of KPMG LLP to provide information technology consulting services while, at the same time, serving as the auditors of New York City Health and Hospitals Corporation ("NYC Health + Hospitals") auditors.

WHEREAS, in 2014 NYC Health + Hospitals, pursuant to authorization of the NYC Health + Hospitals' Board of Directors, engaged KPMG LLP to serve as NYC Health + Hospitals' auditors for a term of four years to expire upon completion of services for fiscal year 2017 or June 30, 2018, whichever is later; and

WHEREAS, in 2013 NYC Health + Hospitals issued a request for proposals to assemble pool of requirements contracts to obtain as-needed information technology ("IT") consultants with the necessary skillsets to meet NYC Health + Hospitals' IT needs, including the Epic Electronic Medical Record program and non-EMR related systems and programs (the "RFP"); and

WHEREAS, by separate resolution presented at the July 2015 meeting of NYC Health + Hospitals' Board of Directors, approval was granted to award contracts to the twenty highest ranked, responsive and responsible proposers with satisfactory or above scores which demonstrated the necessary experience and organizational capacity to provide the IT consulting services sought in the RFP; and

WHEREAS, KPMG LLP, is among the twenty firms to which NYC Health + Hospitals awarded IT consulting contracts pursuant to the RFP; and

WHEREAS, the function of a company's auditors are, under the PAAA, considered to be inconsistent with such auditor providing other services to such company although such inconsistency or conflict, once disclosed to the company, may be waived by its audit committee; and

WHEREAS, the Audit Committee of the Board of Directions of NYC Health + Hospitals has the authority under the PAAA to waive any violation the presumed conflict under the PAAA incident to the engagement of KPMG LLP to provide information technology consulting services while, at the same time, serving as NYC Health + Hospitals' auditors.

NOW THEREFOR,

BE IT RESOLVED, that the Audit Committee of the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") hereby waives, under the Public Authorities Accountability Act any presumed conflict incident to the engagement of KPMG LLP to provide information technology consulting services to NYC Health + Hospitals while, at the same time, serving as its auditors.

EXECUTIVE SUMMARY
AUDIT COMMITTEE WAIVER OF CONFLICT
ON ENGAGEMENT OF KPMG LLP

KPMG LLP ("KPMG") serves as the auditors of the New York City Health and Hospitals Corporation ("NYC Health + Hospitals"). In 2013, KPMG responded to a Request for Proposals to provide staff augmentation services to NYC Health + Hospitals in its Enterprise Information Technology Services ("EITS") division to work on Epic Electronic Medical Record program and non-EMR related systems and programs. Based on a review of all proposals submitted, KPMG was among the 20 firms that EITS chose to receive a contract. In July 2015, the NYC Health + Hospitals Board voted to approve the 20 contracts including KPMG. However, under the Public Authorities Accountability Act (the "PAAA") a firm's work as an auditor is deemed to be in conflict with its performance of any other work for a public client. This prohibition follows considerable negative commentary spurred by high profile cases such as that of Enron and led to the passage of several rules and adoption of best practices of which the PAAA rule is one. However, the PAAA provides that the conflict, presumed to exist when auditor simultaneously performs other services for a client, may be waived by the Audit Committee of the public entity. Thus, the present resolution is being brought only to the NYC Health + Hospitals Audit Committee and does not require submission to or action by the full NYC Health + Hospitals' Board of Directors.

NYC HEALTH + HOSPITALS

AUDIT COMMITTEE OF THE NYC HEALTH + HOSPITALS BOARD OF DIRECTORS

Corporate Compliance Report

February 11, 2016

Table of Contents

I. Record Management - Status Update – NYC Health + Hospitals Records Management Program

Background

1) In December 2015, the Office of Corporate Compliance ("OCC") provided the Audit Committee (the "Committee") with an update of NYC Health + Hospitals Corporation ("the "Health Care Delivery System", the "Health Care System" or the "System") Records Management Program (the "Program").

2) Briefly, by way of background, the System operates and maintains a corporate-wide records management program that is governed by NYC Health + Hospitals Corporation Operating Procedure 120-19 (*Corporate Records Management Program and Guidelines for Corporate Record Retention and Disposal*) and the State Arts and Cultural Affairs Law and the implementing Department of Education regulations thereof. In carrying out its records management program responsibilities, NYC Health + Hospitals has committed itself to, in pertinent part, the following:

- maintaining records generated and kept by NYC Health + Hospitals in the normal course of business in a manner consistent with Federal and State regulations and HHC's own policies and procedures;
- assessing the value of any record prior to determining its disposition; and
- encouraging the systematic disposal of unneeded records.

Use of third-party vendor to store offsite records

3) As reported in December 2015, NYC Health + Hospitals is presently storing 569,926 boxes of paper-based files including, but not be limited to, medical records, x-rays, and the work product of various System departments with a third-party vendor, Recall, formerly CitiStorage, at a current monthly cost of $310,750. As noted in paragraphs 4-5 below, the OCC has taken affirmative steps to reduce the number of records stored that no longer require retention for legal, historical, clinical or other legitimate business purposes.

Summary of Record Management Activities since December 2015

4) As required under OP 120-19, each NYC Health + Hospital facility has appointed a facility records management officer ("FRMO") to identify System records that no longer need to be maintained and to provide information to facility support staff and executive administration as to what is required before those records can be submitted for

destruction. The FRMOs will also be responsible for developing internal controls such as: (i) the inventory of facility-wide records; (ii) the monitoring of records disposal; and (iii) compliance with applicable regulatory requirements.

Meeting with the Deputy Corporate Compliance Officer/Records Management Officer

5) The NYC Health + Hospitals Deputy Corporate Compliance Officer/Records Management Officer William Gurin, met with the designated FRMOs at an initial compliance committee meeting held on January 27, 2016. The purpose of the meeting was to set goals for the Record Management Officers Committee as a means to (i) facilitate the exchange of information between facilities; (ii) coordinate efforts to identify the universe of documents and records stored by NYC Health + Hospitals; (iii) ensure that the requirements of the NYC Health + Hospitals Operating Procedure 120-19 are met; and (iv) reduce costs, pursuant to OP 120-19, through the managed destruction of documents and records that no longer need to retained.

- At the meeting, the off-site storage of records was discussed with a goal set of reducing these off-site records through the FRMOs efforts to identify records for destruction at their respective facilities. Presently, the System is paying a monthly rate for 550,000 boxes of $310,750. Costs go down as we bring the total number of stored boxes under 550,000 boxes. Next steps include providing the FRMOs with the number of boxes stored by their facility and identifying those boxes by department and cost center. The FRMOs will then contact these departments and cost centers to identify records for destruction.

- Also discussed at the meeting was the pending request by the Corporate Records Management Officer for a records management system that would (i) inventory and categorize NYC Health + Hospitals records from the time such records are conceived through to their eventual disposal, which would include identifying, classifying, prioritizing, storing, securing, archiving, preserving, retrieving, tracking and destroying records; and (ii) meet the state regulatory requirements and NYC Health + Hospitals policy and procedures relevant to the corporate-wide management and maintenance of NYC Health + Hospitals records.

- Activities of the FRMOs will be reviewed at the next compliance committee meeting scheduled for April 27, 2016.

Meeting of Record Retention Council ("RRC")

6) The RRC, which is co-chaired by Senior Assistant Vice President/Chief Corporate Compliance Officer Wayne A. McNulty and Senior Assistant Vice President/Acting Chief Information Officer Sal Guido, and includes members from the different System facilities and the Office of Legal Affairs, met on December 15, 2015.

7) At the RRC, the committee members discussed (i) the responsibilities of the RRC pursuant to the newly-revised OP 120-19; (ii) the appointment of FRMOs at the respective facilities; (iii) the storage (and cost) of off-site records at Recall; and (iv) the approval of the purchase of a record management system application that would:

- permit the inventory and management of the locations and contents of corporate-wide folders and boxes of records;
- track the movement of folders and boxes of records;
- capture and manage requests for records or records series;
- offer a data base for the monitoring, control and recording of the destruction of records;
- offer a filing and indexing system for forms requesting the retrieval or destruction of records;
- offer a storage and management system for inactive records that identifies records as they become subject to destruction;
- provide a security classification and access privilege feature that permits the assignment of a security or access classification to either an individual record or a series of records according to rank;
- meet the record life cycle requirements of NYC Health + Hospitals' Operating Policy and Procedures 120-19;
- permit the generation of standard reports that print out as they are seen on the screen; and
- offer functionality that will permit the generation and use of customized forms, correspondence and other records.

E-Discovery Task Force

8) As required under OP 120-19, the formation of the E-Discovery Task Force has commenced. The purpose and function of the E-Discovery Task Force is to review and make recommendations regarding the revision and development of existing record retention practices, policies and procedures, related to the retention, preservation, collection, production, and destruction of electronic records and data (in any form or medium) in the possession, custody, and control of NYC Health + Hospitals where litigation involving NYC Health + Hospitals has commenced or is reasonably anticipated to commence.

- The Task Force is to have its inaugural meeting in late February or early March.

II. Monitoring of Excluded Providers

1) Since the Audit Committee last convened in December 2015, there have been four reports of excluded providers: one at an acute care facility; and three in Correctional Health Services ("CHS").

- One Excluded NYC Health + Hospitals/Kings County Nurse:
  - In December 2015, the OCC learned that a nurse working at NYC Health + Hospitals/Kings County was excluded by the New York State Office of the Medicaid Inspector General ("OMIG") from participation in the State's Medicaid program, effective October 21, 2015. The exclusion report indicates the nurse admitted, in June 2015, to falsely documenting a home visit to a patient. As a result, she received a one (1) month actual suspension of her nursing license by New York's Office of the Professions, with twenty-three (23) month stayed suspension and a two (2) years probation. She was also ordered to pay a one thousand dollar ($1000.00) fine.
  - The subject nurse did not notify her manager or Human Resources regarding the suspension or exclusion. When interviewed on December 30th, 2015, she informed Kings County's Deputy Director of Human Resources, that she has an attorney assisting her efforts for reinstatement to Medicaid.
  - With the assistance of Counsel, the OCC is finalizing a self-disclosure overpayment letter to send to OMIG. It will provide a calculation of the amounts of Medicaid funds we determine are

associated with the services provided by the nurse, which are subject to refund.

- Three Excluded CHS Staff Members:

  - In January 2016, the OCC learned that two staff nurses and one affiliated physician's assistant, assigned to service NYC Health + Hospital's CHS, have records of exclusion by OMIG from the State's Medicaid program.

  - The physician's assistant is a PAGNY affiliated work force member and was excluded by OMIG from the Medicaid program, effective July 1992. Given the age of the exclusion, details regarding the reason are not available. The physician's assistant failed to provide information regarding this exclusion in his employment application. He reports that he was unaware of the exclusion and does not know of a reason for it. He has assured PAGNY's Compliance Officer, that he is sending a certified letter to OMIG requesting removal from its exclusion list.

  - One CHS nurse was excluded by OMIG, effective April 2011. New York's Office of the Professions reports that in January 2010, she was found guilty of professional misconduct, had her license temporarily suspended, was placed on probation and was fined, for having misrepresented on progress notes a home care visit she did not conduct.

  - The second CHS nurse was excluded by OMIG effective June 2012, due to her previously being listed on federal Office of the Inspector General's ("OIG") Sanction list. She no longer appears on OIG's sanction list and additional details are not available. The employment applications and current circumstances for both of these nurses are under review.

III. National Government Services (NGS) reviews

1) As reported during the December 2015 Audit Committee, the OCC is working with Revenue Management to investigate and address several Medicare claims denials. The Audit Committee will be provided with an update on this matter in April of 2016.

IV. Privacy Incidents and Related Reports for the Fourth Quarter of CY 2015

Background

1) The Office of HIPAA Privacy and Security within the OCC is responsible for reviewing, investigating, and responding to potential and confirmed breaches of PHI.

Breach Defined

2) A breach is an impermissible use, access, acquisition or disclosure (hereinafter collectively referred to as "use and/or disclosure") under the HIPAA Privacy Rule that compromises the security and privacy of PHI maintained by the Corporation or one of its business associates.[1]

3) Pursuant to 45 CFR § 164.402 [2], the unauthorized access, acquisition, use or disclosure of PHI is presumed to be a breach unless HHC can demonstrate that there is a low probability that the PHI has been compromised based on the reasonable results of a thorough risk assessment, that is completed in good faith, of key risk factors.[2]

Factors Considered when Determining Whether a Breach has Occurred

4) Under HIPAA regulations, at a minimum the following four key factors must be considered to determine whether there is greater than a low probability that a privacy and/or security incident involving PHI has resulted in the compromise of such PHI:[3]

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed; and
- The extent to which the risk to the protected health information has been mitigated.

[1] 45 CFR § 164.402 ["Breach" defined].
[2] *See* 45 CFR § 164.402[2]; *see also* 78 Fed. Register 5565 at 5643 and 5695 [January 25, 2013]
[3] *See* 45 CFR § 164.402 [2][i-iv].

Reportable Privacy Incidents for the Fourth Quarter of Calendar Year 2015 (October 1, 2105 to December 30, 2015 – hereinafter 4th Quarter"))

5) During the period of October 1, 2105, through December 30, 2015, 35 complaints were entered in the ID Experts RADAR Incident Tracking System. Of the 35 complaints entered into RADAR, 16 were found after investigation to be violations of HHC HIPAA Privacy Operating Procedures; four were determined to be unsubstantiated; eight were found not to be a violation of HHC HIPAA Privacy Operating Procedures; and seven are still under investigation.

- Of the 16 incidents determined to be violations, six incidents were determined to be breaches. A total of 28 individuals were affected by the six confirmed breaches.

V. Compliance Reports for the Fourth Quarter of CY 2015

Summary of Reports

1) For the fourth quarter CY2015 (October 1, to December 31, 2015) there were 89 compliance-based reports (making a total of 358 for CY2015 as of December 31) of which three (or 3.4%) were classified as a Priority "A",[4] 41 (or 46.1%) were classified as Priority "B", and 45 (or 50.6%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints. Of the 89 reports received during this period, 63 (or 70.8%) were compliance complaints received on the OCC's anonymous toll-free compliance hotline.

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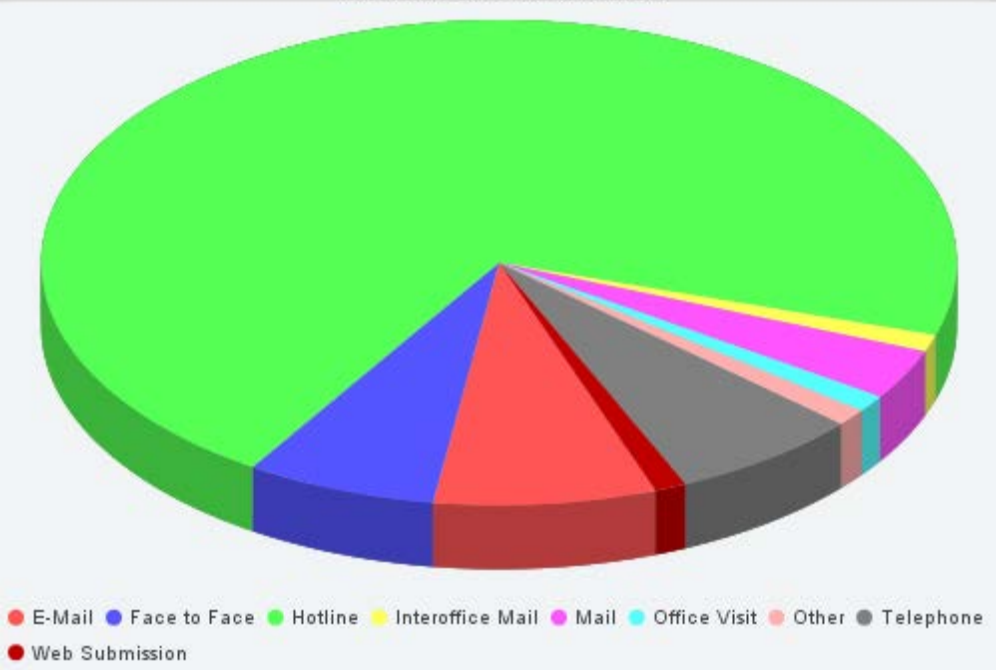
[4] There are three (3) different report categories: (i) Priority "A" reports - matters that require immediate review and/or action due to an allegation of immediate threat to a person, property or environment; (ii) Priority "B" reports – matters of a time-sensitive nature that may require prompt review and/or action; and (iii) Priority "C" reports – matters that do not require immediate action.

Mode of Reporting



2) Below is a summary of how the OCC received the 89 CY2015 fourth quarter reports:

a. 63 (70.8%) were received on the Help Line;
b. 7 (7.9%) were received via E-mail;
c. 6 (6.7%) were received via Face-to-Face;
d. 6 (6.7%) were received via Telephone;
e. 3 (3.4%) were received via Mail;
f. 1 (1.1%) was received via Interoffice Mail;
g. 1 (1.1%) was received via Office Visit;
h. 1 (1.1%) was received via Other Means;
i. 1 (1.1%) was received via Web Submission.

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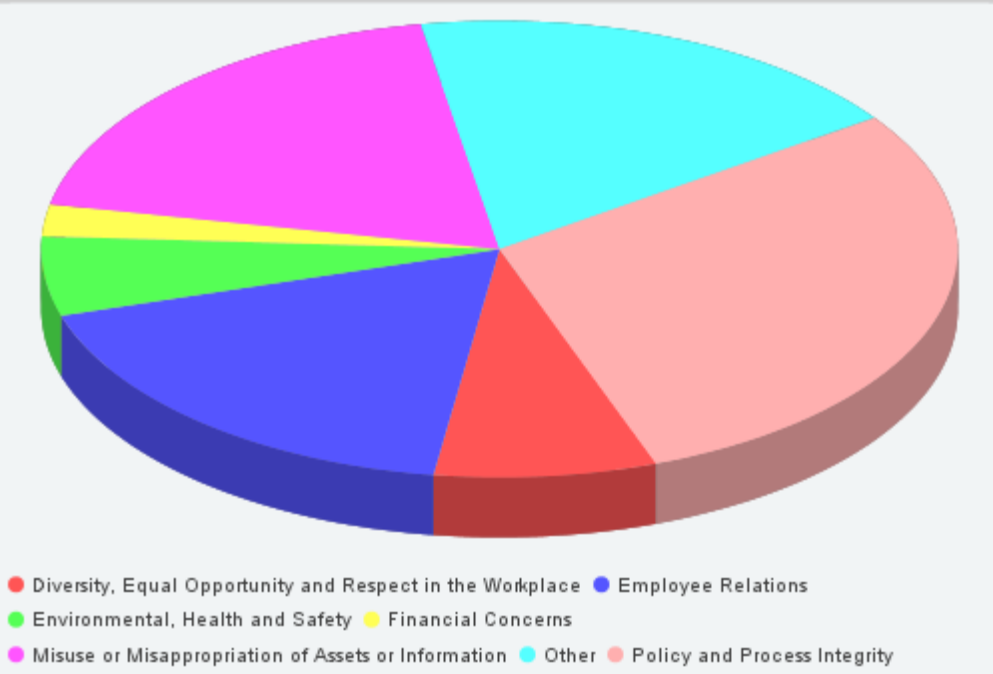
Allegation Class Analysis



3) The breakdown of the allegation classes of the 89 reports received in the fourth quarter of CY 2015 is as follows:

a. 26 (29.2%) Policy and Process Integrity;
b. 17 (19.1%) Misuse or Misappropriation of Assets or Information Other;
c. 16 (18%) Employee Relations;
d. 16 (18%) Other;
e. 7 (7.9%) Diversity, Equal Opportunity and Respect in the Workplace;
f. 5 (5.6%) Environmental, Health and Safety;
g. 2 (2.2%) Financial Concerns.

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VI. HHC ACO, Inc. – Compliance Update

Updating the HHC ACO, Inc., Compliance Plan

Overview

1) As previously indicated to the Audit Committee, the HHC ACO's Compliance Plans must: (1) satisfy applicable law; and (2) be periodically updated "to reflect changes in the law and regulations."[5]

2) Generally, the development of a compliance plan serves the following key purposes:[6]

- Identifies and helps to prevent unlawful and unethical conduct;
- Provides a centralized source for distributing information on healthcare statutes and other program directives related to fraud, waste and abuse; and
- Fosters an environment that encourages employees and others to anonymously report potential problems.

3) The structure of an ACO's compliance plan may be determined by, among other things, the following factors:[7]

- The size of an ACO; and
- The business structure of an ACO.

Next steps/updating the existing Compliance Plan

4) The OCC, in consultation with ACO leadership, has started the process of reviewing and updating the ACO Compliance Plan as needed.

5) The OCC will work closely with the Office of Legal Affairs and its outside counsel throughout the Compliance Plan revision process.

[5] 42 CFR § 425.300 [b][2]
[6] *See* 76 FR 67,802, 67,952 [2011]
[7] 76 FR 67,802, 67,952 [2011]

Update Regarding CMS Warning Letter

6) In December 2015, the OCC reported to the Audit Committee that the HHC ACO recently received a warning letter from CMS, which advised that the HHC ACO does not currently meet the MSSP minimum attainment requirements and recommending that the ACO ensure policy and process changes to improve performance are in place.

- Although the HHC ACO's overall 2014 quality performance ranked at the 76th percentile according to CMS benchmarks, it showed significant deficiencies in a subset of measures that are particularly dependent on systemic weaknesses in chronic condition coding and Meaningful Use execution.

- Each MSSP quality measure benchmark has a 30th percentile minimum performance threshold. The 33 quality measures are divided into four domains: Patient/Caregiver Experience (7), Care Coordination/Patient Safety (6), Preventive Health (8), and At Risk Population (12). CMS requires ACOs to exceed the minimum performance threshold on 70% of the pay for performance measures within each of these four domains.

- HHC ACO did not exceed the minimum threshold on four of the 33 measures, including three from the Care Coordination/Patient Safety domain: Ambulatory Care Sensitive Admissions for COPD or Asthma, Ambulatory Care Sensitive Admissions for Heart Failure, and Percent of PCPs who Qualified for EHR Incentive Payment (the only double-weighted performance measure). Because these cluster in a single domain, which has 6 pay for performance measures in total, HHC ACO met the performance threshold for 2 of 6 (33%) measures in that domain, short of CMS' expectation of 70%. In the other domains, HHC ACO performance greatly exceeds these thresholds.

Management's Response/Corrective Action Plan Update

7) Management has reported the following corrective actions that are planned or already underway to address measure deficiencies:

- *Ambulatory Care Sensitive Admissions*

  - The two Ambulatory Care Sensitive (ASC) Admission measures represent a ratio of observed discharges to expected discharges for patients with a diagnosis of COPD/Asthma or Heart Failure. The

ACO has conducted extensive analysis of performance data in this area, which revealed a major performance distortion driven by HHC's systemic poor chronic condition documentation and coding practices. Based on claims submitted to CMS, the prevalence of COPD and Heart Failure in our population both appear to be less than half of what is expected from nationally representative samples of a mostly Dual Eligible patient population, due to low capture rate of milder secondary conditions on ambulatory visit note problem lists. This means that a performance measure evaluating utilization in a claims-based disease cohort will have a markedly inaccurate and smaller denominator of mostly sicker patients who are more frequently hospitalized, adversely distorting performance.

- HHC ACO developed and deployed targeted education efforts with ACO leadership and clinical care teams over the past year, and will continue to scale up these efforts to improve complete capture of secondary diagnoses in ambulatory note problem lists. This fall it is also launching a program of targeted patient-specific feedback to identify missed documentation opportunities. This is combined with the ACO's core efforts to continuously and proactively identify patients at high risk for hospitalization and connect them with supportive services and care to keep them healthy and in their communities. Notably, HHC ACO has already demonstrated significant progress in both ACS Admission measures from 2013 to 2014: COPD/Asthma admission scores decreased from 3.10 to 2.41 and Heart Failure admission scores from 2.06 to 1.86. ACS Admissions are a key quality indicator for various value-based payment initiatives, including New York's Delivery System Reform Incentive Payment (DSRIP) Program. HHC ACO will work closely with stakeholders across HHC to align its improvement strategy in this area.

- HHC ACO provided facility-based leadership with a report of all patients that where coded as having CHF and/or COPD in 2014 but for whom no diagnosis had yet been coded for 2015. Clinical teams were instructed to alert providers at the patient's next appointment to review and confirm the diagnosis, if appropriate.

- *Percent of PCPs who Qualified for EHR Incentive Payment*

  - NYC Health + Hospitals has chosen to participate in the New York Medicaid EHR Incentive Program, under which Eligible

Professionals (EPs) that deliver services in HHC facilities will demonstrate "meaningful use" of a certified EHR technology. NYC Health + Hospitals made a concerted effort to satisfy program requirements in 2014; unfortunately, EP attestation was not completed in time to meet the MSSP measure deadline.

- NYC Health + Hospitals developed a work plan with dedicated resources to ensure that all HHC EPs attest successfully in 2015. Because HHC ACO performance is a significant vulnerability in this corporate-wide process, NYC Health + Hospitals will prioritize primary care providers that are likely to be in the MSSP measure denominator.

- The workgroup that is responsible for Meaningful Use activity-which includes PCIP, IT, Finance and PhyCARE- continues to work to ensure that NYC Health + Hospitals employed and affiliated providers meet Meaningful Use requirements for 2015. PhyCARE has placed representatives on site at each facility on a rotating schedule starting in December, 2015 to help providers complete necessary attestations. HHC ACO shared its list of "priority' primary care providers with facility-based leadership so that they could communicate the importance of meeting with PhyCARE.

8) A follow-up report on this matter will be provided to the Audit Committee in April 2016.

VII. DSRIP/OneCity Health - Compliance Update

Status of compliance activities

1) The OCC continues to work with OLA and its outside counsel and OneCity Health Leadership to continue to develop the DSRIP compliance program.

2) In addition to OCC's internal efforts, it serves on behalf of NYC Health + Hospitals/OneCity Health as an active member of the Greater New York Hospital Association ("GNYHA") DSRIP Compliance Work Group. The GNYHA Work Group, which includes most of the Performing Provider System ("PPS") Leads in the New York City area, is collaborating on, among other things, the development and content of DSRIP specific compliance training.

3) At the present, the OCC, with the assistance of a third party vendor, performs monthly database searches to determine if any NYC Health + Hospitals workforce

members, vendors or PPS partners have been excluded from participation in any government healthcare programs. Under the PPS Partner Master Service Agreement, PPS partners are also required to perform excluded party searches for their work force members. If a DSRIP partner discovers that it has an excluded party engaged in DSRIP activities, it must promptly report this to NYC Health + Hospitals/OneCity Health. Excluded parties are barred from working for NYC Health + Hospitals or its DSRIP partners.

DSRIP Compliance activities are ongoing

4) As the solidification and implementation of DSRIP-related compliance requirements and guidance from OMIG and DOH DRSIP-program requirements continue to take place (and GNYHA accordingly continues to issue guidance on the same), NYC Health + Hospitals DSRIP compliance activities are in a state of constant flux and redevelopment. As such, the OCC will over the next several months continue to develop its compliance program to include oversight of DSRIP-related risks. Likewise, the OCC will in the upcoming months rollout DRSIP training and education efforts, such as: (i) System-wide advisories pertaining to DSRIP fraud, waste, and abuse prevention; (ii) making training and education available to DSRIP partners for their use at their discretion and for modification to fit their particular organization; and (iii) amending System-wide compliance training to include DSRIP compliance topics during the next compliance training cycle in July 2016.

VIII. Gotham Health FQHC, Inc. – Compliance Update

1) On January 28, 2016 Senior Assistant Vice President/Chief Corporate Compliance Officer Wayne A. McNulty and other OCC staff members, met via telephone conference with Gotham Health FQHC, Inc. (“Gotham Health”), Board Members Dolores McCray, Paul Covington, and Herbert Smith to discuss Gotham Health compliance activities.

2) The OCC will provide the Gotham Health Board with a compliance update in late March or early April 2016.

3) The OCC is presently developing computer-based compliance training for Gotham Health Board members.

IX. Compliance Training Update

Status of Board of Directors Training Module

1) Audit Committee Chairperson Emily Youssouf and President/CEO Ramanathan Raju, MD, both evaluated and successfully completed the NYC Health + Hospitals Board of Directors Compliance and HIPAA Training Module. The topics covered in the training include the following

- Overview of Compliance and the NYC Health + Hospitals Corporate Compliance and Ethics Program;
- Board Member Compliance Responsibilities;
- Relevant Federal and State Law including Stark Law and Antikickback Statute; and False Claims Act;
- HIPAA;
- Conflicts of Interest, Principles of Professional Conduct ("POPC"), and Code of Ethics;
- Records Management and Medical Record Documentation; and
- HHC ACO, Inc., Compliance Program.

2) Enterprise-wide Information Technology Services ("EITS") is working closely with the Office of the Chairperson and the OCC to make the subject compliance training module available on the I-Pads of Board Members.

Status of Corporate-wide Training

3) As of January 29, 2016, the System-wide compliance training completion rates are as follows:

- Physicians Module: 77%;
- General Workforce Module: 48%; and
- Healthcare Professionals Module: 82%