

AUDIT COMMITTEE  
MEETING AGENDA

December 1, 2015

1:00 P.M.

125 Worth Street,  
Rm. 532  
5<sup>th</sup> Floor Board Room

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CALL TO ORDER

- Adoption of Minutes October 8, 2015

Ms. Emily A. Youssouf

ACTION ITEMS

- KPMG June 30, 2015 Management Letter

Ms. Maria Tiso

INFORMATION ITEMS

- Internal Audits Update
- Compliance Update

Mr. Chris Telano

Mr. Wayne McNulty

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

## MINUTES

AUDIT COMMITTEE

MEETING DATE: October 08, 2015

TIME: 12:30 PM

### COMMITTEE MEMBERS

Emily Youssouf, Chair

Josephine Bolus, RN

Jo Ivey Boufford, MD (VIA VIDEO CONFERENCE)

### STAFF ATTENDEES

Antonio Martin, Executive Vice President/COO

Sal Russo, General Counsel, Legal Affairs

Deborah Cates, Chief of Staff, Chairman's Office

Patricia Lockhart, Secretary to the Corporation, Chairman's Office

Marlene Zurack, Senior Assistant Vice President/CFO, Corporate Finance

Ross Wilson, Senior Vice President/Corporate Chief Medical Officer

Michelle Allen, Deputy Chief Medical Officer

Victor Fleming, Associate Director, Medical & Professional Affairs

Julian John, Corporate Comptroller

Gassenia Guilford, Assistant Vice President, Finance

Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits

Wayne McNulty, Corporate Compliance Officer

Karen Gallinari, Senior Compliance Officer

Kevin Rogan, Senior Compliance Officer

Leithland Tulloch, Senior Director, Office of Facilities Development

Marshall Bondy, Deputy Corporate Comptroller

Jozef Dubroja, Assistant Director, Central Office Finance

Alice Berkowitz, Assistant Director, Central Office Finance

Darren Ng, Senior Systems Analyst, Central Office Finance

Devon Wilson, Senior Director, Office of Internal Audits

Chalice Averett, Director, Office of Internal Audits

Carol Parjohn, Director, Office of Internal Audits

Delores Rahman, Director, Office of Internal Audits

Carlotta Duran, Assistant Director, Office of Internal Audits

Rosemarie Thomas, Audit Manager, Office of Internal Audits

Frank Zanghi, 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

Sam Malla, Senior Auditor, Office of Internal Audits

Barbarah Gelin, Senior Auditor, Office of Internal Audits

Gillian Smith, Senior Auditor, Office of Internal Audits

Melissa Bernaudo, 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  
Roshney Kaur, Staff Auditor, Office of Internal Audits  
Linda Maldonado, Staff Auditor, Office of Internal Audits  
Sandy Bhigroog, Staff Auditor, Office of Internal Audits  
Sheldon McLeod, Chief Operating Officer, Kings County Hospital Center  
Ernest Baptiste, Executive Director, Kings County Hospital Center  
Anthony Saul, Chief Financial Officer, Kings County Hospital Center  
Ron Townes, Associate Director, Kings County Hospital Center  
Anthony Rajkumar, Executive Director, Metropolitan Hospital Center  
Jeanette Roman, Senior Associate Director, Metropolitan Hospital Center  
Tracy Green, Chief Financial Officer, Metropolitan Hospital Center  
Edie Coleman, Controller, Metropolitan Hospital Center  
Nicole Guijarro, Associate Director, Metropolitan Hospital Center  
Denise Soares, Senior Vice President, Generations + Northern Manhattan Health Network  
Caswell Samms, Chief Financial Officer, Generations + Northern Manhattan Health Network  
Dorothy Buzzeo, Associate Executive Director, Lincoln Medical & Mental Health Center  
Walter Otero, Associate Executive Director, North Bronx Health Network  
Glenn Hazel, Associate Director, Harlem Hospital Center  
Jay Weinman, Chief Financial Officer, Bellevue Hospital Center  
Elsa Cosme, Chief Financial Officer, Gouverneur Healthcare Services  
Sue Ling Lee, Associate Executive Director, Gouverneur Healthcare Services  
Darren Collington, Associate Executive Director, Coney Island Hospital  
Martin Novzen, Senior Associate Director, Woodhull Medical & Mental Health Center  
Jose Santiago, Controller, MetroPlus Health Plan

#### **OTHER ATTENDEES**

**PAGNY:** Luis Marcos, CEO; David N. Hoffman, Compliance Officer; Walter Ramos, General Counsel; Reginald Odom, Chief HR Officer; Anthony Mirdity, Chief Financial Officer; Wendy Vung, Controller; Sabina Zak, Corporate Administration Officer; Ellen Giesow, Corporate Administration Officer; Allan Vergara, Corporate Administration Officer; Robert McKenna, Corporate Administration Officer; Katherine Kreutz, Corporate Administration Manager

**KPMG:** Maria Tiso, Partner; Jim Martell, Partner; Joe Bukzin, Senior Manager

**WATSON RICE:** Bennie Hadnott, Partner

**OMB:** Kent Cherney, Unit Head

**MINUTES**  
**OCTOBER 8, 2015**  
**AUDIT COMMITTEE OF THE BOARD OF DIRECTORS**  
**NYC HEALTH + HOSPITALS**

An Audit Committee meeting was held on Thursday, October 8, 2015. The meeting was called to order at 12:31 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 September 17, 2015. The minutes were unanimously adopted by the Committee. An additional motion was made and seconded to hold an Executive Session of the Audit Committee to discuss matters of potential litigation. Ms. Youssouf then introduced the first information item regarding the Fiscal Year 2015 Financial Statement and Related Notes.

Mr. Julian John, Corporate Comptroller stated that he would like to thank KPMG, (Jim Martell, Partner; Maria Tiso, Engagement Partner and Joe Bukzin, Engagement Senior Manager and their team for working closely with the Corporate Comptroller's office to get the financial statements completed in a timely manner and this was in spite of getting the pension report from the New York City Comptroller's office very late on Friday. It was due on Wednesday but despite that we were able to work through the reports and get the financials completed. Mr. John also thanked Chris Telano and his team for their supporting audit and the other areas within the finance partners because everyone sort of pulled together to get all of the necessary data. Mr. John also stated that he would like to take a second to thank James Linhart, Deputy Comptroller; Marshall Bondi and Joseph Dubroja for their help and their hard work during the course of the audit. They worked very hard and he really appreciates what they have done. We lost four people to retirement in March, and despite that the team pulled together to get the financials done.

Ms. Youssouf stated that she had heard nothing but wonderful things about all the work you and your team have done and thanked them.

Mr. John reported that KPMG has completed audit of the Corporation's financial statements for 2015 and will issue an unqualified opinion. In 2015 the Corporation adopted GASB Statement # 72, Fair Value Measurement and Application. This guidance requires entities to expand their fair-value disclosures by determining major categories of debt and equity securities within the fair-value hierarchy on the basis of the nature and the risk of the investment. The statement only requires additional disclosures and did not have an impact on the financial statements.

Mr. Bukzin said that this guidance was discussed during the planning procedures. There was enhanced disclosures primarily around investments. It does not deal with re-measuring the value of fixed assets. It was just disclosures around the government security obligations. You will see a couple of footnotes that have been incorporated into the financial statements this year.

Ms. Tiso commented that this GASB guidance came after the FASB, so the Financial Accounting Standards Board had already sent this guidance out for public and nonpublic entities already, so the chart had just come out for a couple entities.

Mr. John continued with Significant Financial Ratios Comparisons - the current ratio is financially indicated in the measure of the Corporation's ability to pay off its short-term liabilities with current assets, and it is determined by the ratio of current assets and current liabilities. Ideally we would like to have a ratio of one or better, but for the current year our ratio was .84, last year it was .87.

Days cash on hand - HHC ended the year with 35 days cash on hand. Last year, it ended the year at 19.5, and this year we had a much higher number because at the end of the year in the fourth quarter we received approximately \$600 million in UPL payments as well as \$100 million in DSRIP payments.

Net days revenue in patient receivables decreased from 71.91 in 2014 to 61.19 in 2015, that is primarily due to the efforts by the facilities in improving their collections.

Mr. John reported that Net position is the difference between the Corporation's assets and liabilities. Net assets decreased by \$395 million, net liabilities decreased by 314 million between 2014 and 2015. Accordingly, the Corporation's net deficit position grew by \$81 million. Mr. John then proceeded to provide highlights of the Fiscal Year 2015 financial statements, as follows:

### Assets

- Current assets decreased by \$ 205 million.
- Cash and cash equivalents increased \$268 million primarily due to a receipt of \$600 million for two years of retroactive inpatient upper payment limit funds during the fourth quarter. \$319 million pertaining to State Fiscal Year '13 and \$280 million pertaining to State Fiscal Year '14.
- Grants receivable increased \$60 million due to a delay of payment of the Medicaid Administration grant.
- Patient accounts receivable, net decreased \$58 million due to an increase in collection effort and a decrease in the risk incentive pool payable between MetroPlus and HHC.
- Estimate third-party payor settlements decreased \$540 million due to receipt of \$1 billion of UPL payments.
- Due from the City of New York decreased \$40 million due to receipt of collective bargaining payments from the City.
- Capital assets, net decreased \$74 million due to major retirement of assets related to Goldwater. Buildings, leasehold improvements and equipment, net of accumulated depreciation decreased \$138 million, and that was netted against construction in progress increase of \$64 million.
- Other assets decreased \$13 million primarily due to a decrease in assets restricted as to use of \$11 million resulting from the use of the Construction Fund for various capital projects.
- Deferred out flows – Unamortized refunding costs which represents the amortization of loss on bond refunding. This was implemented after GASB 65, which we did last year. Decreased \$3 million from 2014.

### Liabilities

Total liabilities, in 2015 decreased by \$314 million compared to 2014.

- Current liabilities decreased \$247 million. Decreases in estimated pools payable and estimated third-party payable, which were offset by increases in the amount due to the City of New York and current portion of pension.
- Estimated pools payable – decreased \$259 million primarily due to a decrease in the State's advance payments for Disproportionate Share or DSH Hospital and DSH Max funds of approximately \$354 million.
- Estimated third-party payor settlement payable - decreased \$32 million primarily due to a re-estimation of third-party anticipated take-backs both for Medicaid and Medicare rate change.
- Current portion of pension increased \$9 million as the Corporation recognized its annual pension costs and payments towards its liability as determined by the New York City Office of the Actuary.
- Other non-current liabilities and long-term liability – based on the advice of the auditors and the approval of OMB, we agreed to move \$300 million into these two categories.
- Due to the City of New York, increased \$36 million.
- Other noncurrent liabilities increased \$300 million was due to reclassification of our FY '15 debt service and malpractice practice payments due to the City of New York from current liabilities to long-term liabilities.

Ms. Youssouf asked that you said that the \$300 million turns into other noncurrent liabilities and that noncurrent means long-term liability. To which Mr. John responded yes.

- Long-term debt, net of current portion, decreased \$58 million due to the payment of current debt obligations.

- Pension, net of current portion, increased \$289 million due to the Corporation's recognition of its annual pension costs and payments towards its liability as determined by the New York City Office of the Actuary.
- Post-employment benefits obligations other than pension or OPEB, net of current portion, decreased \$148 million as the Corporation recognized its annual OPEB credits and costs, again, as determined by the New York City Office of the Actuary.
- Deferred in flows decreased \$450 million due to changes in the net differences between projected and actual earnings on pension plan investments from 2014 to 2015. These balances are derived from the pension report issued by the New York City Office of the Actuary.

### Income Statement

Operating loss, the difference between operating revenue and operating expenses, decreased by \$30 million with a loss difference of \$63 million in 2015 compared to \$93 million in 2014.

### Operating Revenue

Operating revenue increased \$69 million primarily due to increases in net patient service revenue, grants revenue and other revenue offset by a decrease in the appropriations from the City of New York.

- Net patient service revenue, increased \$76 million due to the recognition of risk pool payments from MetroPlus, \$95 million, increases in DSH Max, \$43 million, and a decrease in UPL payments of \$84 million.
- Other revenue increased \$10 million primarily due to \$6 million increase and 340B program revenue.
- Grants revenue increased \$241 million primarily due to the recognition of \$137 million for IAAF payments and \$117 million of DSRIP grant revenue.
- Appropriations from the City of New York decreased \$259 million primarily due to the fact that in 2014 the City and HHC agreed that debt service and malpractice payments for 2013, \$150 million and \$122 million respectively, would not be paid, which resulted in the total amount of \$272 million being recorded as appropriations from the City of New York.

Ms. Youssouf asked what year the debt service malpractice payments were for. Mr. John answered 2013, the 2014 debt service and malpractice payments are still due to the City as of 6/30/2015, and we subsequently made those payments in August of 2015.

### Operating Expenses

Operating expenses increased \$39 million primarily due to increases in personal services, fringe benefits/employer payroll taxes, OTPS, pension and affiliation contracted services, and this was netted against decreases in OPEB and depreciation.

- Personal services - increased \$68 million primarily due to collective bargaining settlements and an increase in FTEs of approximately 795.
- Other than personal services - increased 39 million, and that is primarily due to increased cost of pharmaceuticals, \$28 million, and an increase in IT software maintenance expenditure of \$17 million.
- Fringe benefits and employer payroll taxes - increased \$50 million due to health benefit increases of \$27 million and increases in welfare benefits of \$17 million
- Pension - increased \$61 million as determined by the New York City Office of the Actuary.
- Affiliation contracted services - increased \$72 million due to market adjustments and enhanced services. Approximately \$30 million of that increase is for increased staffing and salary increases.

- Post - employment benefits other than pension, OPEB, decreased \$239 million as determined by the New York City Office of the Actuary and is predicated on assumptions for healthcare actuarial gain experience, cost trends updated to reflect recent past experience and future experience.
- Depreciation decreased \$11 million due to the loss on retirement of assets at Goldwater.
- Other changes in net assets - decreased \$207 million due to changes in the following components. Capital contributions funded by the City of New York decreased \$197 million due to fewer continuing major modernization projects.

Ms. Youssouf asked how is that related to the decrease from the City Capital budget, is it the same?

Ms. Zurack responded that it is really point in time because the amount that would have been contributed would have really been from projects two, three years ago coming online, so it was the taper off from that period that you are seeing. We had a very robust period of major modernization with Henry J. Carter and Harlem, so it is just tapering off, but because of what you are saying about the City contributions, it should go down in future years even further.

Mr. John Continued with MetroPlus:

- Cash and cash equivalents - decreased by \$126 million primarily due to increases in the required statutory reserves and long-term investment activities.
- Premiums receivable increased \$64 million due to an additional IGT accrual of \$50 million.
- Accounts payable and accrued expenses - increased \$10 million due to increase in New York State accruals for incarcerated members, \$7 million, and premium over payment estimate of \$5 million.
- Premium revenue increased \$250 million, and that is because of growth. There was an increase in Medicaid members of 41 thousand.
- Other than personal services - increased \$216 million for medical expenses related to increased services and growth. Pharmacy costs increased \$123 million. Additionally, HHC risk expense increased by \$49 million.

Ms. Youssouf requested to explain what you mean by HHC risk expense in this context.

Ms. Zurack stated that HHC and MetroPlus have the relationship of insurer and provider, so HHC's contract with MetroPlus is a percent of premium contract for medical services, 86 percent of premium is for medical services, so MetroPlus has to set aside 86 percent of their premium for medical services, some of which are provided by HHC and some of which are provided by other providers, Coney Island network, or the network for MetroPlus is broader than HHC.

After claims are paid for specific services, if in fact those claims are lower than that number that was set aside, that 86 percent, that difference comes back to HHC as a risk payment because HHC took risks. If in fact it had gone over, HHC would have to pay the difference, so we have actually very successfully preserved premium revenue by having this kind of arrangement and benefitted because we are able to get reasonable money coming from MetroPlus to HHC, and one could argue because we have done this for so long that we are kind of in a position where value-based purchasing that is a little bit a head of the rest of the industry, and we have the same kind of arrangement with Health First, slightly different details but conceptually similar.

Mrs. Bolus asked to explain how HHC is paying for the incarcerated member? To which Ms. Zurack answered that once you are incarcerated, you are no longer on Medicaid. So if you had been a MetroPlus Medicaid member, the State might not have real time information on the incarceration date, so the State might pay. Let's say Wayne is a MetroPlus member and June 1st the State paid MetroPlus for his premium, and on June 5th he was incarcerated. MetroPlus owes,

New York State, 25 days of the premium because they are not allowed to give Medicaid premiums for incarcerated members.

Ms. Youssouf asked if MetroPlus sets aside a certain percentage as a reserve to cover this, or do they just pay it out of current income?

Ms. Zurack said that that is their normal – that is not the reserve. That is part of their normal sort of working capital issuance.

Ms. Youssouf then turned the meeting over to KPMG.

Ms. Tiso saluted everyone and introduced herself as Maria Tiso, the lead audit partner for the account, to her right Joseph Bukzin, who is the senior manager on the account. To her left is Jim Martell who is the Healthcare Resource Industry partner and to his left is Bennie Hadnott the partner from Watson Rice LLC.

Ms. Tiso stated that she will not go through all of the details of the presentation. That she is going to go through a lot of high-level information. Page three is deliverables -- these are the deliverables that were reported to you during the audit planning meeting in June. We are here today to go through all the required communications and the final result of our audit. In November we will be coming back to the Committee to go through our management letter observations. We are just wrapping up the audit, so we are in the process of putting together our observations at the moment. We will be issuing various regulatory cost reports in 2016, and then also we will be doing an audit of the MetroPlus HHC Insurance Company and ACO, so those will be coming in December year end.

On page four and five is the description of management's responsibility, KPMG's responsibility and the Audit Committee's responsibility. Management's responsibility is making sure the internal controls are working effectively in order to prevent, detect and deter fraud and obviously making sure that the financial statements and all the disclosures in the financial statements are appropriate in accordance with generally accepted accounting principles. KPMG's responsibility is to render an opinion on the financial statements, and the Audit Committee's responsibility is one of oversight monitoring, and the Audit Committee does rely on management, the internal auditors and the external auditors as it relates to the financial statements.

Ms. Tiso said that KPMG intends to issue an unmodified opinion on the financial statements, which is the highest level of assurance, that the financial statements are free of material misstatement. Mr. Bukzin will go through some of the findings and the results of the audit.

Mr. Bukzin saluted everyone and said that they had one corrected adjustment during the course of the audit for approximately \$20 million. It resulted in some updated calculations for certain components of third-party reimbursement. It resulted in a reduction to the net patient service revenue. That has been recorded and reflected in the financial statements. The other item mentioned that Mr. John alluded to earlier was the classification due to the City for about \$300 million to long-term liabilities. The new accounting pronouncement described earlier at the bottom part of the page describes some of the significant accounting estimates where we devoted a significant amount of time during the audit. These balances are reasonably stated, and we do involve certain subject-matter professionals such as reimbursement professionals, actuaries to assist us as part of reviewing the amounts that are listed in the line items in those financial statements.

Ms. Youssouf stated that it says that you are still doing the valuation of the pension plan liability.

Ms. Tiso added that as of yesterday evening, they received a concluding memo from their pension actuary specialist stating that he has completed his review, so that area has been completed.

Mr. Bukzin continued and said turning to page seven, he wanted to highlight some of the significant accounting transactions during the year. The first one relates to the Interim Access Assurance Funds that were received of which \$136.9 million has been recorded within the financial statements. We spent a bit of time working through the DSRIP accounting treatment this year. There was approximately \$111 million that has been recorded as part of grant revenue. During that process we did consult with our national office since it was unique in terms of the transaction, and we wanted to

make sure it was recorded proper and appropriately in an appropriate period, and it has been concluded that it is properly reflected as grant revenue. Towards the middle of the page, we spoke a bit about the UPL balances. We did want to provide some insight into what transpired from last year's balance to the current year balance. Last year's balance was approximately \$1.4 billion. Approximately a billion of that has been collected, and there is also an increase for 2015 UPL with in the receivables.

In terms of the electronic medical records system, there are disclosures around this within the fixed asset footnote, and in terms of certain balances, the capitalized costs related to this project are \$115 million as of the end of the fiscal year. In terms of expenses related to the project, it is approximately \$13.6 million recorded in the financial statements. On the bottom of the page, during 2015 the organization did receive grant funds for FEMA for approximately \$33 million. That has also been reflected as part of grant revenue.

Page eight we just wanted to highlight a couple of subsequent event items. The first is disclosing of number seven, financial statements. It describes the line of credit arrangement related to equipment financing. The Corporation drew down approximately \$10 million just after the fiscal year end, and note 15 of the financial statements describes the memorandum of understanding related to the correctional health services, and there is a budget for this for fiscal 2016 of approximately \$159.3 million, which is funded by the City of New York.

Ms. Tiso said that the last bullet on that page talks about liquidity considerations. When the audit plan was presented, this was an item that we look at every year as part of our audit plan, so some of the key performance indicators that we look as it relates to the Corporation when we work in capital, we looked at operating loss of income, we have looked at cash flow from operations, and then we look at the net position of the Corporation over all.

For Fiscal Year '15 there were two positive indicators. The first one was including MetroPlus and HHC. The Corporation over all had a loss of \$14 million last year but generated income from operations of \$44 million this year. Again, positive trends. The other positive indicator was the operating cash flow. The organization had about \$ 452 million of cash flow from operations. Again, another positive trend. The other thing was the working capital. It is relatively break even. It's been probably the first year over a couple of years that it's slightly below working capital. It is a working capital deficiency of about \$72 million, so it is something that the organization should look at going forward, but again, still we looked at liquidity. Everything looks fine at this point in time to issue an unmodified opinion.

Ms. Youssef asked that does any of that have to do with the payments that were delayed to HHC?

Ms. Zurack responded that essentially, this is really what in the next 12 months do we expect in terms of new assets versus liabilities, and the liabilities are largely consisting of money owed to the City. But there is other things in there as well, and that is now in the wrong direction, and that really speaks to a very challenging budget for Fiscal '16. In the next 12 months we think you are going to have more of a loss here because your current assets are not sufficient to pay your current liabilities, so it is a problem, and unless either HHC can figure out ways to do things more efficiently and create savings or generate additional revenue, that is going to be a problem in next year's budget, and when KPMG comes back next year for Fiscal '16, unless something is changed, I think you might not be able to be so optimistic at this point.

Ms. Tiso said exactly, so each year we have to evaluate both qualitative and quantitative aspects of liquidity, so we look at each year separately. Hopefully, things will move differently next year where your current assets will be in excess of your current liabilities.

Ms. Tiso continued with page nine -- these are some of the other required communications, just quality of accounting principles have been consistently applied, and they are disclosed in the financial statements. Mr. Bukzin talked about the management judgments and accounting estimates, and we concluded that they were reasonable, and yet as it relates to audit misstatements, there was one corrected audit adjustment that we saw went out before, and there were no material uncorrected financial statements to disclose to the Committee.

Page ten there were no unresolved disagreements. To the best of our knowledge management did not consult with other auditors to get a different opinion. We obviously as part of our audit do discuss issues. We had healthy discussions, but again, no difficulties encountered in performing the audit.

There will be three material written communications. One was the engagement letter that was signed by the committee, a management representation letter and a management letter, which we will be presenting in November. We discussed the significant and unusual transactions, and at this point as we look at the observations that will be included in the management letter, we do not note any significant deficiencies and material weaknesses at this point in time.

Page eleven, as part of our audit we do have various SAS 99 audit procedures, which we meet with key levels of senior management to talk about various transactions, if they are aware of any fraud. We believe that the Committee is aware of anything that was spoken to us at that in those meetings. There were no significant changes to the initial 2015 audit plan. If there were any scope changes, we obviously would have discussed it with you during this meeting, and noncompliance with laws and regulations, nothing that came to our attention, and litigation claims and assessments, nothing noted other than the normal course of business items.

Page 12, lists items that we need to complete in order to issue the final report. We are finalized with the concurring partner review. We have received all of his comments, and his edits are actually included in the financial statements that you have, so we are pretty much done with his review. We talked about the GASB 68 pension review -- that was finalized yesterday evening. We are still doing some test work on consulting costs, and hopefully we will be wrapped up with that shortly. Then we have subsequent event procedures, down to date legal letter inquiries and any minutes that we have not inspected as of this point in time that are not drafted. We need to get management's rep letter, the final debt covenant calculations based on the final numbers. We were working on the final financial statements up until probably 8:00 yesterday evening, and then again management letter observations, which we are in the process of doing, and that completes our formal presentation.

Ms. Youssouf asked if there were any questions.

Dr. Boufford congratulated the staff for a clean letter – it is an amazingly complicated set of statements.

Ms. Youssouf asked if the committee can get a little color on how HHC looks with their counterparts around the country.

Mr. Martell responded that if you take a step back and you try to compare HHC to what you would think would be comparable, the first thing is there is no real such animal that is comparable with HHC . We all know that HHC is a unique organization. HHC is a head of its game as Ms. Zurack said relating to a lot of the things they are doing. The risk sharing, the local systems are just getting involved. They have never done that and they are experiencing a significant amount of pain and suffering losses trying to create this insurance company, so as you go a long that route, I think the one issue that has been a positive for HHC is obviously getting into the game of risk sharing insurance-type business years ago.

Quite frankly, the liquidity issue is tough. More of the major academics are obviously doing better, not only from the operating care, but they also have a strong philanthropy, which assists. When you take a step back and just compare yourself to local things like that, it is difficult. Your mission has different goals, and that has to be taken into account. I have been involved almost 25 years off and on in, in some form or fashion. We have had discussion relating to liquidity that went back ten years, and then the Corporation comes back.

DSRIP will be a major issue matter going forward. Controlling that and identifying it and working with the PPSs, we are the lead in certain ones, will be clearly the next step in healthcare transformation in terms of how do you provide services to the environment. So the old bricks and mortars that we see, the 11 hospitals and all the buildings, may change, and it may be more of a population help, more into the ambulatory care clinics and things of that nature where perhaps those are where the investments are. So what we see today of HHC may not be the H HC you see in five or ten years. I don't know if I answered your question.

Ms. Youssef answered yes and sorry I asked it.

Ms. Zurack stated that she would like to disclose that HHC has had a slight marginal change in some of the City numbers since the version you have before you, so when the Committee is ready to vote to approve the statements, I would like to ask the Committee a caveat plus or minus one percent for minor changes that we have to do tonight and tomorrow.

Ms. Zurack asked for a vote. The committee voted unanimously to approve with plus and minus one percent.

Ms. Youssef then directed the meeting to Chris Telano for the audit update.

Mr. Telano thanked her and saluted everyone and said that the audits that he will discuss today are all about the PAGNY affiliation agreements. Before I start out, I just want to commend PAGNY on the efforts they have given since last year to resolve prior audit issues. Although progress has been made, there are still some areas that need to be addressed, and I will go through those areas shortly. As you can see on page four of the briefing the audits encompass seven different facilities, Lincoln, Harlem, Jacobi, North Central Bronx, Metropolitan, Coney Island and Kings County. The objectives of the audits were to evaluate the internal controls and processes pertaining to the affiliation agreement. Keep in mind that these audits included a review of both PAGNY and HHC operations as it relates to the affiliation agreement.

During the course of the audits at the seven PAGNY facilities, various issues were found at each site. Many of the issues noticed were similar to those of previous year audits. In addition some of our conclusions found while reviewing the subcontractor's activities were the same as those found by the New York City Comptroller's Office during their audit of the Lincoln affiliation. Specifically, the failure to submit the required time sheets or documentation to support payments and the lack of current service agreements.

For example, at Lincoln we found on 9 of the 35 invoices that we reviewed, totaling \$436,000, did not have time sheets or other appropriate documentation. Payments were made for 4 of 35 invoices we reviewed, totaling \$396,150 for services provided without a contract in place or an expired contract at the time of service. We also noted that although PAGNY has established an annual contract compliance review process, we were only provided with 1 review of the 26 Lincoln subcontractors for agreements with automatic renewals. We also noted there were payments for \$187,500 each month that were being paid in advance of orthopedic services provided. We found two such checks during our review of 35 invoices.

At Harlem we found that PAGNY processed payments for providers under two of the nine subcontract reviewed for which they are not listed as a party on those agreements. One contract is between HHC/Harlem and New York Presbyterian, and the other contract is between HHC/Harlem and an employment agency, Solomon Paige.

Ms. Youssef asked if it means that somebody got paid twice? To which Mr. Telano responded no.

Ms. Youssef asked if he insured that Harlem did not pay as well. Mr. Telano answered yes, we did.

Mr. Telano continued and stated that at Jacobi and/or North Central Bronx we noted 4 of 37 invoices, totaling \$189,000 were approved and paid for services that were not supported by time sheets. Time sheets were also unavailable for department chairs for surgery and neurology, that received an additional stipend under a subcontractor agreement. Also in Jacobi, the Montefiore Medical Center was paid \$33,000 a month to provide ultrasound and fetal surveillance services from June 2013 to May 2014 without a contract. In addition, the physicians from Montefiore did not submit time sheets as supporting documentation for payment. Payment was based on the physician schedules and invoices provided by Montefiore. As such we found PAGNY approved and paid eight invoices totaling \$278,000 for services provided under this agreement. We also noted that there was not an annual review of the subcontracts for agreements with automatic renewals. We were not provided any documentation.

At Metropolitan 2 of 30 payments that we reviewed totaling \$22,000 were paid to vendors without time sheets to validate the receipt of the services. Five of the 30 payments we reviewed, totaling over \$11,000, were dispersed to EPIC Staffing Agency without a subcontractor agreement. We also asked for an annual contract compliance review, and we were provided three out of the nine. Lastly, regarding Metropolitan, one of the nine subcontractors reviewed received monthly advance payments totaling \$568,000 for services received subsequent to the payments.

In Coney Island 3 of 30 check requests reviewed, totaling \$246,000, were approved and paid without 8 time sheets being signed by the department head attesting to services that were paid.

The affiliation contract also states that gastroenterologist services at Kings County Hospital Center should be conducted by employees or contract services providers. However, we did not find individuals on the PAGNY payroll register who performed this service. Instead the gastroenterologist physician providers were paid \$239,000 through PAGNY's account payable system as a vendor without a subcontractor agreement.

When we reviewed the subcontractor files, we noted there was documentation missing related to criminal background checks, and we also noted expired medical clearances at Lincoln and Harlem. We noted time keeping errors at Jacobi, Harlem and Metropolitan. At Jacobi it was noted that time sheets had hours for holiday, vacation and sick days processed in error as regular time worked. At Harlem and Metropolitan we found time sheets in which the hours recorded did not agree to the amount paid. There were also some issues in which HHC and PAGNY bore some responsibility, and those issues are related to system access still for terminated employees, those systems being our medical records system, QuadraMed, and our email system, Group wise. And lastly at the time of the completion of our audits, the annual recalc documents for all PAGNY facilities were not completed for Fiscal Year 2014.

Mr. Martin asked if the services were provided? Mr. Telano responded yes.

Mr. Martin then said that this was really a failure of time keeping or documenting recordkeeping, so clearly this is something HHC and PAGNY will work together to make sure is done. I just really want the Board to know that the services were provided, and that is very important. Again, I think the recalcs, have been completed through 2014, so all of the recalcs for all of our affiliates happened and have been completed, have been signed off on. I believe at the time the audit was done they were not, but they are all current now. We continue to have a problem with system access, and I think that is something I guess we share responsibility on. I do not know whether it is the failure of the affiliate to notify us timely or it is the failure of HHC to remove the respective individual from the system, but as you know, we did put a process in place where IT is supposed to be handling this, so I will revisit this again and really try to make sure that we are much more compliant in the future. It should be noted, I think Mr. Telano said this at the very beginning, there has been significant improvement over the past year. I think the audit a year ago was really very, very harsh, and there has been significant improvement. The issues that were brought up are something that we will work together with PAGNY.

Dr. Boufford asked that I am interested in what is the management structure for PAGNY at the individual institutions Is everything done centrally, or are there actually officers on site managing the affiliation contract with each hospital or at two hospitals or whatever?

Mr. Martin answered that there is a PAGNY administrator at site at each one of the hospitals.

Dr. Boufford asked if you have any patterns around the competency of those individuals, or do you think it's just an infrastructure issue as described, the systems are poor and they have not been focusing on it?

Mr. Telano responded that he thinks they are just improving their processes, from the very beginning they were poor, and they are just improving year by year, and there was some movement, some transition among the affiliation offices before or during the course of our audit, which resulted possibly in some of these comments.

Dr. Boufford asked if there is some formal training of their folks? And that that would be worth finding. Mr. Telano responded that he did not know.

Mr. Martin asked if she means training that PAGNY gives to the administrators onsite? Dr. Boufford answered yes, to help fulfill the affiliation contract obligations to the Corporation.

Mr. Martin stated that he assumes that they do, but will follow up with that and bring it back.

Dr. Boufford stated that we have had this conversation. I do not know that it's fully accepted, but arguably if you look at them as your physician practice embedded in HHC, I think arguably there could be a different relationship around their competence in terms of accounting and accountability to the Corporation than with some of the other affiliates.

Mr. Martin stated that he agrees and he thinks one of the things that we have attempted to do, particularly in the most recent past, is really have a much more collaborative of us working together much more closely. We realize that PAGNY is a really valued partner for us and that we need to really work together very closely to ensure success, so whatever we need to do we are committed to do in the Corporation.

Ms. Youssouf stated that I would just say that, again, for everybody to remember, please that although it does not always seem like it, Internal Audits is your friend because Internal Audits will find these things and help you correct them prior to it really getting out of hand or causing any major financial issues, so it is important for everybody to always continuously cooperate with Internal Audits and heed to their advice.

Mr. Martin added that I want to echo that, I think one of the things that was heartening to me was hearing that 95 percent of the recommendations have been complied with, so over the course of the Internal Audit during their investigation, our facilities have taken it seriously and have implemented 95 percent of those recommendations. I think that shows a good partnership.

Ms. Bolus stated that for the record PAGNY is here, so we do know they complied and came to this meeting. I want to make sure it's on the record they are here.

Dr. Marcos stated that my name is Luis Marcos. I am the CEO of PAGNY and I am happy to be here with you. I thank the Committee. We have been talking the past month and so on to try to improve the situation at PAGNY, and I appreciate very much the help from the administration, Mr. Martin, and the executive directors and Chief Financial Officer that are here. I thank Mr. Telano, I think he is doing the best he can. I think he could do better, but that is my personal opinion. What I would like to say, and I appreciate the statements made that we are doing better, we still need to improve. I want to also say that we disagree with some of the findings. I am glad that Mr. Martin asked the question have we paid for things that we did not receive, services, and the answer is no. So when you hear all these numbers, paid for this, paid for that, double pay or whatever, keep in mind that PAGNY has not, to my knowledge, over paid or taken money or do something illegal, right? I think that has to be taken into account when numbers are given out without the full explanation.

Having said that I think that we need to improve. I am not an auditor. I am simply a shrink by training, and I think that we need to improve the process. For example, as it has been mentioned, many of the findings at PAGNY but also the hospital, and it takes many players to be able to solve some of these issues. There are other issues where PAGNY, frankly, has no control over it. For example, if a physician leaves Coney Island at 5 and starts working at Bellevue at 5 p.m., there is no way for PAGNY to know if other hospitals within HHC or others have our own physicians working there as well, so there are many examples of that kind.

Finally, I do not want to take your time. Just to say that in the past eight months or nine months PAGNY has underwent 15 audits. When you think of PAGNY, we have about ten employees per facility, ten employees, and that counts me, so we are not really an affiliate that has resources beyond. We went through 15 audits, so we would like to suggest, respectfully, that those be taken into account when we schedule audits, and audits take months, and sometimes it takes from three to five months for PAGNY to receive the final report, so if we can all work together so that we can continue the improvement with your support, Madam Chair and the Committee and HHC, I think that you can all then be proud of what PAGNY did. Thank you for your patience.

Ms. Youssouf thanked him and asked if there are any other questions?

Mr. Telano stated that one of the goals of Internal Audits is to ensure that we find issues before a government agency finds the issues, and at the audit done of the Lincoln affiliation by the City Comptroller's Office, they found numerous invoices, I believe \$1.3 million worth that lacked supporting documents. They also found 5 out of 30 vendors without current contracts, so we cited the same things to give warning that if the Comptroller's Office comes back, these are the type of issues that are going to be cited by them, so that's the reason we note them also. The Comptroller's Office did not state that

there were no services provided, but they could not be sure because there was a lack of documentation, and that was the concern.

Ms. Youssouf said that I appreciate that and I also would like you to know, Mr. Telano, you have the full confidence of this Committee, so thank you. We move on to Mr. McNulty for the Compliance update.

Mr. McNulty saluted everyone and said to turn to page three of the Corporate Compliance report. My name is Wayne McNulty, Senior Assistant Vice President, Senior Corporate Compliance Officer. I will start with the compliance of the Deficit Reduction Act of 2005. On an annual basis, HHC is required to disseminate to all its contractors, employees and work force members a summary of its policies and procedures designed to prevent and detect fraud, waste and abuse. We are also required to ensure that all employee handbooks have information regarding the Deficit Reduction Act.

At the end of September, we disseminated to our entire work force and to over 1400 contractors and vendors a summary of the Deficit Reduction Act. We also summarized our policies and procedures, namely our corporate compliance plan, our principles for conduct, our operating procedure for compliance programs and also our compliance plan in general and our guide to compliance, and those are set off on pages three to five of the report with some detail.

On page five, section two, the monitoring of excluded providers, we have no reports of excluded providers to report since the last time the Audit Committee convened in September. The Office of Corporate Compliance is presently awaiting results being performed by our vendor of the September review.

Moving on to page six at the top, section three, I am going to provide an update of the calendar year 2015 risk assessment process. As previously reported from the period of mid-July to the period of September, we had 25 compliance risk meetings at the various facilities and at Central Office.

If you turn to the next page, paragraph three, I just want to update the Committee on three compliance committee meetings that we had since the last time the Committee convened. We had a OneCity Health / DSRIP Compliance Program Committee, which was held at Central Office. We also had a compliance committee meeting for the HHC Accountable Care Organization. Both OneCity Health and Accountable Care Organization are wholly owned subsidiaries of HHC.

We also had a compliance committee meeting for the World Trade Center Health program. We have to have a follow-up meeting with regard to the World Trade Center Health program, and then we have to have just one more executive compliance committee meeting and we will be finished with the risk-assessment process and we will have a Corporate compliance work plan to present to the Board in executive session the next time the Audit Committee convenes.

If there are no questions with regard to the risk-assessment process, I will move on to section four, compliance training. We are required at HHC because we participate in the Medicaid program under the compliance regulations to provide training and education on compliance issues to all effective employees and persons associated with HHC, and that compliance training must reach the governing body of HHC. We have four different modules of training, which is outlined in paragraph two. We have a training for Group 11 employees and other designated employees. We have training for all the physicians throughout the Corporation. We have training for all the healthcare professionals, and we define healthcare professionals as individuals licensed under Title 8 of the Education Law, so occupational therapists, nurses, respiratory therapists. We also have training for the Board of Directors. The training for the Board of Directors is the only training that is not live yet. It is right now under review. We are hoping that we will have a version for Ms. Youssouf to look at early next week, and after she reviews the same along with Dr. Raju, we will then have that ready for the Board of Directors to take a look at and complete their compliance training.

Moving along, please turn to page nine, I just want to provide an update of the results of the compliance training. If you look at page nine, the current status, paragraph one, in July of this year, the physician module, we have 56 percent completion. The healthcare professional module we had 69 percent. We had not implemented the general workforce module at that time. As of October 1st, we have 63 percent of completion on the physician module, we have the healthcare professional 76 percent completion, and the general work force just started beginning of September, so we do not have

those numbers. I will be working with the executive directors, senior vice presidents, chief operating officers and the chief medical officers of each facility to bring up the numbers with respect to the healthcare professionals and the physician modules over the next couple of weeks. Moving along to section five of page nine, I just want to provide an update on the delivery system reform incentive payments compliance program. As previously reported to the Committee in June, the federal government recently agreed to allow the State of New York to reinvest nearly half of its savings generated through the Medicaid Redesign of reforms. The majority of funds used by the State for reinvestment have been allocated for DSRIP activities.

Turn to page ten. On December 18th the Board of Directors approved by resolution the repurposing of the HHC subsidiary Assistance Corporation to function in the capacity of a centralized service organization for the purpose of providing technical assistance to HHC, who has been designated by the State as a PPS lead in the DSRIP program. Office of the Medicaid Inspector General has issued guidance with regard to the required compliance program elements for DSRIP. If you turn to page 11, you will see that there are eight elements. I presented these eight elements in June, but what I want to update the Board on is there are two elements that have changed.

If you turn to page 12, OMIG issued guidance originally on April of 2015 about the eight elements, and on September 1, 2015, retracted their initial April guidance. There were two changes. Change one was with element number 6 on page 12. Initially they wanted the PPS to perform a risk assessment on the distribution of the use of DSRIP funds. Now they would like the PPS to perform a routine identification of risks, which we have done with the risk-assessment process and formed the DSRIP compliance committee. Element seven there is a particular change. They wanted before for the lead PPS, which is HHC, to look at the misuse of DSRIP funds. That meant the misuse within the PPS system. Through lobbying through the greater New York, OMIG has come back with some revision to that guidance, and now they want the PPS lead to specifically look at its own willful misuse of DSRIP funds or false statements made by PPS providers with respect to obtain DSRIP funds. It is a slight change, but it should make it easier for us to comply with those particular elements.

Moving along, if you could turn to page 14 of the report, I just want to briefly go over some corporate governance requirements under the Public Authorities Accountability Act of 2005 and the Reformation Act of 2009, which is collectively referred to as PAAA. Both HHC and One City Health, because it is a wholly owned public benefit corporation, it has to establish a governance committee, it has to establish an audit committee, it has to be made up of a majority of independent members. The Office of Corporate Compliance, the Office of Legal Affairs, the One City Health leadership and the Office of Medical Professional Affairs are working together jointly to make sure that all PAAA requirements will be met, and I will report back to the Audit Committee in December as far as our progress on that.

Moving along to paragraph number 9 on page 14, as stated before, we established a DSRIP compliance committee. The compliance committee has key leadership from Finance, IT, Legal and Medical and Professional Affairs and Labor. The DSRIP compliance committee met on October 1, 2015, and we assessed, scored and prioritized different DSRIP related risks, and we will be developing a DSRIP compliance plan for the year. I should say a DSRIP compliance work plan for the year, and we will report that in December when we report our final work plan for the Corporation. With respect to compliance staffing for DSRIP purposes, the Vacancy Control Board approved the posting of a position for DSRIP for senior compliance personnel, and we should be posting that position sometime next week.

If there are no questions about the DSRIP compliance program, I'll move on to page 16 for the last section of the report. It is under HHC ACO Compliance Activities Update. We previously reported in June to the Audit Committee with regard to the HHC ACO compliance activities and the number of participants. I just also wanted to report that in both 2013 and 2014 ACO met its quality reporting standards and achieved a seven percent reduction in Medicare expenditures for its population. If you turn to page 17 paragraph 5, you can see the different quality performance measures that we have to meet, and also if we could turn to page 20, rather, on paragraph 13, I would like to discuss the ACO compliance plan. ACO has to develop a compliance plan, and they have five elements. These five elements are somewhat different than the eight

elements that are required under New York law because this is a federal law that governs the ACO. In summary these elements are designation of a compliance officer, the implementation of risk identification process, employee training, law-enforcement reporting and a mechanism for employees to report compliance issues. These elements are outlined in detail on pages 20 to 24. We have all of those elements in place, and we have completed the risk assessment process and we are developing the ACO compliance work plan over the next couple of weeks.

If you turn to page 24, paragraph 23, this is just the makeup of the ACO compliance committee meeting. We have representation from ACO. We have representation from Medical and Professional Affairs and representation from Compliance and also the Office of the General Counsel.

If you turn to page 25, as previously indicated on September 17, we had the ACO compliance committee meeting and identified several ACO compliance risks, which will be incorporated into the corporate compliance work plans. Paragraph 26, we just want to remind the Audit Committee that the HHC ACO recently submitted a renewal application to extend its participation in the Medicaid shared status program from 2016 to 2018. CMS will issue its decision on application later this year, and I will update the Audit Committee in December with regard to any other ACO compliance activities. We need to review the compliance plan for ACO. As we are required to do under law, we have to periodically review, and if necessary we will make amendments within the next month or two.

Then Mr. McNulty stated that if there were no questions that that will conclude my report.

Ms. Youssouf stated that if there no questions, then I am going to call an executive session.

After returning from Executive Session, Ms. Youssouf asked if there were any old business or new business.

There being no further business, the meeting was adjourned at 2:23 P.M.

Submitted by,

Emily Youssouf  
Audit Committee Chair

December 1, 2015

The Audit Committee of the Board of Directors  
New York City Health and Hospitals Corporation

Ladies and Gentlemen:

In planning and performing our audit of the financial statements of New York City Health and Hospitals Corporation (the Corporation), a component unit of the City of New York, as of and for the year ended June 30, 2015, in accordance with auditing standards generally accepted in the United States of America, we considered the Corporation's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we do not express an opinion on the effectiveness of the Corporation's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Corporation's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses, as defined above. However, material weaknesses may exist that have not been identified.

During our audit, we noted certain matters involving internal control and other operational matters that are presented for your consideration. These comments and recommendations, all of which have been discussed with the appropriate members of management, are intended to improve internal control or result in other operating efficiencies and are summarized as follows:

Observations marked with an (\*) have been carried forward from the prior year and updated for the current year.

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HEALTH AND HOSPITALS CORPORATION**

Matrix of Observations

June 30, 2015

Network	Facilities Audited in 2015	Review and Approval of Consultant Costs	Financial Statement Preparation of the Statement of Cash Flows	Affiliation Contracts	Accounts Payable Sub ledger to General Ledger Reconciliation	Formal Review of Third Party Reimbursement Estimates	Information Technology	Purchase Order Process	Industry Issues
Corporate		X	X	X	X	X	X		X
Generations + Northern Manhattan	Renaissance D&TC								
	Harlem Hospital Center								
South Manhattan	Bellevue Hospital Center								
	Gouverneur Nursing Facility D&TC							X	

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North Bronx	Jacobi Medical Center								
North Brooklyn	Woodhull Medical & Mental Health Center							X	
Queens	Elmhurst Hospital Center								

DRAFT

## **Review and Approval of Consultant Costs**

### *Observation*

The Corporation is in the process of implementing an electronic medical record (EMR) system which has an estimated budget of approximately \$764 million over a six year period. Of the \$764 million budget for this project, approximately \$355 million is budgeted for implementation support and training (consulting costs) over the six year period. During 2015, more than \$24.5 million of consulting costs were capitalized and approximately \$13.6 million of EMR related costs were recorded as operating expenses.

Although a large scale information technology project of this nature is infrequent and several layers of governance are established and in place to monitor the overall EMR project, the Corporation should continue to enhance its controls over the review and approval of consultant costs. Based upon the observations identified within the OIG report and preliminary findings from the Office of Internal Audit, certain findings were noted. Some of these findings included lack of supporting documentation attached to invoices, discrepancies for hours worked, and time sheets were not being approved by the appropriate supervisor.

### *Recommendation*

We recommend that the actual hours worked by the consultants be summarized, approved and attached to the invoices for payment. Appropriate required signatures of either the consultant, manager or both on the timesheets are required as supporting documents. Prior to payment, there should be a thorough review by an appropriate individual to ensure that all proper supporting documents required for payment are attached prior to payment being made.

### *Management response*

EITS is in the process of implementing an automated time sheet tool to be used by the IT consultants which will require each of the consultants to enter time worked as well as maintain an activity log of the tasks. The target date for full implementation is December 2015.

## **Financial Statement Preparation of the Statement of Cash Flows**

### *Observation*

There were several adjustments relating to the preparation of the statement of cash flows prepared by management. HHC should revisit its process for accumulating and reporting activities within the statement of cash flows including ensuring its controls are designed and operating at an appropriate level of precision to detect a material misstatement in the statement of cash flows, which may include classification between categories (e.g., operating, investing, capital and noncapital financing) or within a category of cash flow activities. Determining the appropriate

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category for cash receipts and cash payments can involve significant judgment and might differ depending on the substance of a particular transaction. The process should specifically identify:

- Significant, complex and or non-recurring transactions requiring special presentation and disclosure considerations;
- New transactions entered into or new business activities that may affect the cash flow statement;
- Changes in accounting literature with a potential effect on the cash flow statement;
- Noncash transactions requiring disclosure; and
- Noncash transactions embedded in the Statement of Revenue, Expenses, and Changes in Net Assets.

*Recommendation*

We recommend that management implement a process whereby there is a formal review of the direct and indirect method cash flow statement to ensure the appropriate classification between cash flow categories for recurring and non-recurring transactions.

*Management Response*

We are implementing a senior level review process as well as changes to our automated system to correct the issue and will be available for next year.

**Affiliation Contracts \***

*Observation*

The Corporation contracts with affiliate medical schools/professional corporations to provide patient care services at its facilities and reimburses the affiliate for expenses incurred in providing such services. As such, affiliation contracted services is a significant expense for the Corporation and the monitoring of the expenses associated with these contracts requires the cooperation of various departments both within and outside the Corporation.

During the course of our test work in conjunction with the review of the compliance audits performed by HHC's Internal Audit, we noted that recalculation documents are not prepared on a timely basis which has the potential to lead to future adjustments.

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*Recommendation* The Affiliates, Office of Professional Services and Affiliations (OPSA), Corporate Finance and the Facility Contract Managers should perform reconciliations between the affiliates and the facilities on a timely basis in accordance with the contract agreements.

*Management Response*

The Affiliates, OPSA, Corporate Finance, and the Facility Contract Managers have worked diligently during the year to closeout outstanding Recalculation Documents (recalculations) for all previous years. All recalculations through Fiscal Year 2014 have been executed as of this writing.

Furthermore, to facilitate review, Finance and OPSA revised the recalculation documents and OPSA will provide them to the Affiliates for their use. In the meantime, OPSA will continue to meet with facilities and approach the recalculation process in an integrated manner to expedite final review and execution. This process was implemented in FY 15. It involves developing a schedule for completion and meeting with the facilities and affiliates shortly after OPSA reviews a draft. A list of issues are presented and reviewed and a timetable is agreed on to resolve them. The list is used to monitor resolution of issues. OPSA follows up to ensure issues are addressed timely. Once completed the documents are submitted to Finance for their review. Any follow-up is completed by OPSA with facilities for resolution.

**Accounts Payable Sub Ledger to General Ledger Reconciliation \***

*Observation*

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

*Recommendation*

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

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*Management Response*

The Corporation does not currently have systems in place which would allow the Corporate Comptroller office to provide KPMG with requested sub-ledger report. Until such a time as the Corporation invests in new systems, our current legacy based systems are unable to provide a reconciling report that is being requested; however, in its place, management has put forth and proved out a process in which year to year transactions flow from the OTPS Management System to the General Ledger are tracked and reconciled. This practice has proved to be accurate going back a dozen years. Management will continue to work with I.T. to develop reports which reconcile, and we will continue this process until new systems are in place.

**Formal Review of Third Party Reimbursement Estimates**

*Observation*

Management updates and adjusts its financial records based upon calculations and account analysis received by the third party reimbursement department. During our review of the third party account analysis, we identified errors in the calculations for certain estimates and other adjustments to the changes in estimate disclosure within the notes to the financial statements. The change in estimate disclosure related to third party payors is an important disclosure as it provides a user of the financial statements with information pertaining to amounts recorded through net patient service revenue in the current year that pertain to prior periods. As a result, management concurred and recorded one corrected audit adjustment for approximately \$20.2 million related to third party issues (i.e. Medicaid IPRO liability accrual for \$16.5 million and a reduction to a recovery audit contractor (RAC) receivable of approximately \$3.7 million), which resulted in a reduction in net patient services revenue as well as revisions to the disclosures within the financial statements for third party payor changes in estimates.

*Recommendation*

We recommend that management develop policies and procedures to ensure timely communication between the finance and the reimbursement department. In addition, that account analysis from the reimbursement department should be reviewed by the appropriate department supervisor and that a detailed review is performed by an individual other than the preparer of the analysis.

*Management Response*

Corporate Reimbursement services has implemented a template similar to the one used by the Corporate Comptroller's office in order to document review levels. The template specifically requires separate Reimbursement Department preparer, reviewer and department head sign-

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offs. This level of review and documentation provides accountability and further ensures that calculation errors and other omissions are caught prior to acceptance and final sign-off.

**Information Technology**

**Password Settings Leading Practices**

*Observation*

- Password setting and maintenance for access to the network and mainframe applications should be reviewed and updated based on industry best practices. For example, Minimum Password Length: A minimum password length of 6 characters does not match the industry practice of 8 characters for the network and mainframe applications.
- Password Lockout: For the other than personnel services system (OTPS), we found that the configuration setting for password lockout was set to zero attempts, which did not meet industry practice of five failed login attempts. For the network, we found that the configuration setting for password lockout was set to 10 attempts, which did not meet industry practice of 5 failed login attempts.
- Password History: For mainframe applications, we found that the configuration setting for password history was set to zero previous passwords remembered, which did not meet the industry standard of 3 previous passwords remembered. For OTPS, we found that the configuration setting for password history was enabled, but could not determine the exact number of previous passwords remembered due to system limitations. For the network, we found that the configuration setting for password history was set to zero previous passwords remembered, which does not meet industry practice of three previous passwords remembered.
- Password Complexity: For OTPS and the network, we found that complex (Alpha-Numeric) passwords were not required.

*Recommendation*

We recommend that the password configuration settings be enhanced to be in line with industry leading practices. Passwords should include a minimum length of 8 characters and be complex. The system should have a feature that prevents the use of previously used passwords. Additionally, the system should lockout any user that fails three log in attempts. Furthermore, HHC should clearly define acceptable settings with the Security Policy.

*Management's Response*

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Due to system limitations, our Mainframe systems can do the following, but we cannot achieve all industry practices as stated above:

**Password Length** – Currently, minimum password length for the network is set to a length of 6 characters. This is due to applications, including mainframe login's that are tied to the network login, which at this time, cannot accept a larger minimum. HHC is working to resolve this in order to meet the recommended length. The mainframe can only handle a maximum of 8 characters, thus the minimum is set to 6 characters, which is currently system limitation.

**Password Lockout** – The password lockout for OTPS applications is set to lock the account after 5 bad attempts; and will unlock the user after 5 minutes. The network is currently set to lock out the account after 10 bad attempts and keeps the account locked for 30 minutes. This was based on Microsoft recommendations and best practices. Further information can be provided as needed.

**Password History:** The password history for the network is currently set to zero as indicated above. This is due to the network login synchronization spanning across three separate network logins required. The program used to synchronize the password between these systems cannot synchronize the password history. Also, users can currently reset their passwords independently in each of the three network logins. Setting password history for all or one network logins could potentially cause confusion with users resetting their passwords. While we recognize that this is not a best practice, it is a technical limitation. Once the network logins have been consolidated, we will set password history according to industry standards. The mainframe does remember the previous password, so when a user is prompted to reset their password or resets it on their own, they cannot set it to the same as the previous password. To clarify an additional point, the default for remembered passwords for OTPS is 60.

**Password Complexity:** The password complexity has not been set due to the same application limitations as mentioned for the 6 character limit on the passwords. Once the application limitations are addressed, this will be set according to industry standards. Currently, applications such as PSMS and GEAC are controlled by additional application security which requires terminal and operator ID's. Second level access is also required for applications such as timekeeping, Employee History, NALU etc. WEBTERM profiles additionally provide another level of security and are tied to the user's three network accounts.

An updated Security Policy addressing all of the above setting is currently in draft and all settings will be updated and enforced when the policy is completed, the network login consolidation is completed and updates are made to the corresponding applications.

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**User Access Review**

*Observations*

- 1) During our test work, we identified a terminated user who remained on the active Data Center listing. After further inquiry KPMG noted that at the time of termination, the user's ID card was turned in and disabled, therefore the user has no physical access to the data center.
- 2) We noted that 5 of 15 users were not disabled from the active directory in a timely manner, however none of these users were found to have access to the applications. Additionally, we noted that a terminated user was found to be active within the OTPS application. After further review, we noted that this user did not appear on the list of active users from active directory, therefore the individual could not access the OTPS application.
- 3) During the course of our test work related to new system users, 17 of the 25 selected samples, did not provide any approval documentation. Additionally, we noted that HHC does not have a "User Access Review" process where levels of access that each user has within an in scope application is being reviewed.
- 4) HHC does not have a User Access Review' process where levels of access that each user has within an in scope application is being reviewed periodically.

*Recommendations*

To address the observations identified, we recommend the following:

- 1) Management should incorporate access removal with the off boarding of employees. Additionally, incorporating physical access into the access review process could capture this type of oversight.
- 2) Management should review the notification process between the human resource department and the Information Technology department to identify any gaps in notification to eliminate the untimely removal of access.
- 3) Management should maintain all documentation related to the approval of access.
- 4) Management should implement a periodic user access review to ensure that user access rights are appropriate and in line with a user's responsibilities. The review should include completeness and accuracy requirements over the listings being removed.

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*Management's Response*

To address all the items listed above, the Corporation is currently implementing an Identity and Access Management System called IdentityIQ (IIQ) which will allow for a more tightly integrated process in disabling user access across the corporation. The IdentityIQ system is not only an industry recognized leader, but a Gartner Magic Quadrant leader for several years. Upon implementation, IdentityIQ will be integrated in with the human resources management system (PeopleSoft) and information technology ticketing system (Remedy) to ensure that as an employee's status changes, their account status changes accordingly for both the network and related applications. All of this activity is tracked in the ticketing system using the service request management process allowing for additional notification and workflow including to areas that manage physical access (for example Security for badge access). The IdentityIQ system will also allow for reporting and auditing of access that is managed by the system, which will then allow the Corporation to establish a consistent policy on user access reviews for both levels of access and additional electronic attestation of the user that verifies the continued need for the access.

Currently all access requests for network are tracked through the Remedy ticketing system and for OTPS and mainframe all access requests are kept online in the employee reference folder. The changes to access for mainframe and OTPS are granted after receiving approval from the department heads and these requests are handled through access change requests. As mentioned in the previous paragraph, through the use of the IdentityIQ system, NYCHH will be able to better integrate and automate the above access reviews in the future.

**Site Visits**

**Purchase Order Process**

*Observation*

During our procurement process test work we noted a purchase order for services was dated subsequent to the invoice date at Gouverneur and Woodhull, which is not considered to be a leading practice. Other entities within the Corporation issue another purchase order prior to exceeding the initial purchase order's limit. However, the instances identified were not considered to be unauthorized purchases as contracts were in place with the respective vendors.

*Recommendation*

We recommend that management implement controls and update policies and procedures to ensure that services completed under services contracts are being monitored and reconciled to contracts and to purchase orders (PO) on a timely basis. In the event a purchase order is

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approaching its initial limit, an updated purchase order should be issued. We also recommend that the policies and procedures put in place are consistently followed throughout Corporation.

*Management Response*

*Gouverneur* – Since KPMG’s visit to Gouverneur, additional training has been implemented and a standard operating procedure has been put in place with the following steps: requisitions must be created, approved and a purchase order issued within a one month timeframe. The accounts payable department gets copy of purchase order at the same time as the vendor to close the loop.

*Woodhull* – Department managers and staff will be in-serviced on appropriate HHC procurement policies with emphasis on timely execution of contract purchase orders to ensure uninterrupted PO coverage. Cost Group Managers will be required to ensure all monthly OTPS Audit Trail Reports are reconciled by departmental managers to identify any purchase order requiring update within the next 60 days.

**Status of Prior Years Comments**

During the course of our test work, we noted several areas in which the prior year management letter recommendations were addressed. These remediated comments are listed below.

**External Financial Reporting Package Review**

*Observation*

HHC is required to upload their quarterly financial reporting packages to the Electronic Municipal Mark Access (EMMA) database in accordance with their bond obligations. Although management has several levels of review prior to presenting the financial reporting package to the Finance Committee approval, management does not currently have internal controls in place to ensure that the version presented to the Finance Committee is the version that is posted to the EMMA website.

*Recommendation*

We recommended that management ensure that the version posted externally to the EMMA website is compared to the version that was approved by the finance committee and those in charge of governance.

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*Management response*

The Corporate Comptroller's office has implemented policies and procedure to review the EMMA website and verify that the web posting is consistent with the version presented to the Finance Committee.

*Resolution status*

Beginning with the first quarter of fiscal year 2015, the Corporate Comptroller's office has initiated a quarterly process in which the Assistant Director of Fiscal Affairs reviews the EMMA website upon notification of posting by the Corporate Debt Finance division. Log is contained which cross checks the version of the financials approved by the Finance Committee to that which is posted on EMMA. Any inconsistencies are brought to the immediate attention of the Director of Debt Finance for correction.

**Accrued Expenses**

*Observations*

Management's policy does not require the network facilities to perform a detailed analysis and review of accrued expenses and adjust accruals quarterly. Accrued expenses are generally adjusted annually and are subsequently reversed in the following fiscal year end.

Management also identified invoices for approximately \$8.8 million that were not accrued as expense on a timely basis and resulted in a post-closing adjustment to the financial statements.

*Recommendation*

In light of regulators' heightened scrutiny of financial reporting and the Corporation's required quarterly financial statements reporting to the Electronic Municipal Market Access (EMMA) database, we recommended that management adjust accruals quarterly.

Management should ensure that there is adequate communication between the various departments and the finance department for the recording of accrued expenses. Management may also consider centralizing the accounts payable process to possibly avoid delays processing expenses timely.

*Management response*

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The Corporate Comptroller's office instructs facilities to accrue appropriate expenses at year-end. Management agrees that the Corporation should accrue expenses at least quarterly to be reflected in its internal quarterly financial statements. Management will explore the best method to ensure that all appropriate costs are recorded on an accrual basis.

*Resolution Status*

Facilities as part of their prior normal course of action, have been advised to reverse their accrual posted for prior year and create new accrual for fiscal year end. In years prior, these accruals were posted with no automatic reversal, and would stay open on books for each successive quarter as that amount was utilized as an estimate for each quarters' end. For current year end close, facilities were advised to post these same accrual entries as a reversing entry, and new accrual would need to be booked for each quarters' end. Corporate Comptroller's office will monitor each facilities quarterly accruals for adherence to change in accrual policy.

**Affiliation Contracts**

*2014 Observations*

- Graduate Medical Education (GME) time studies were incomplete and inconsistent with payroll records.
- An internal audit review of the corporate Physician Affiliate Group of New York, PC (PAGNY) related expenses during fiscal 2014 was not performed in accordance with the affiliation agreements. The audit was not performed due to the lack of cooperation by PAGNY senior executive management.
- In the prior year, we included various observations and recommendations that were previously identified and communicated to the audit committee by the Office of Internal Audit through their own compliance audits. We are aware that the audit committee has been working closely with the Office of Internal Audit to resolve those matters.

*Recommendation*

KPMG recommended that:

- Management should monitor the payroll record of GME and require them provide complete and accurate time sheets for services provided.

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- Given the nature and size of the contract and expenses, we recommend that a review of these expenses at PAGNY corporate be performed by the internal audit department.

*Management response:*

The Office of Internal Audits conducted an audit of the Graduate Medical Education (GME) time studies in FY14 and found incomplete and inconsistent payroll records. For FY15, based on our risk assessment we did not do a follow-up. However, the Reimbursement department will continue to in-service the departments to ensure the GME time allocation survey reflect the time actually on the time sheets, perform a semi-annual sample audit, and update the instructions to include examples requiring additional guidance. The departments are reminded of the importance of the survey to be compliant with Centers for Medicare & Medicaid Services regulations.

The Office of Internal Audits has completed the requested review of expenses of the Corporate PAGNY affiliate. Fieldwork commenced in November of 2014 and a final audit report was completed April of 2015. All of the OIA findings were presented at the June 2015 Audit Committee meeting, and Management from the PAGNY Finance and Human Resources departments agreed with all findings and have taken the necessary steps to correct each specific issue as noted during the audit.

**Capitalization of Software Costs**

*Observation*

The Corporation is currently implementing its electronic medical record system. During fiscal year end 2014, the Corporation incurred approximately \$5 million of payroll and payroll related costs relating to the implementation of the electronic medical record system. We noted that these costs were expensed rather than capitalized.

*Recommendation*

We recommended that management review all costs incurred with the implementation of the electronic medical records project to ensure that all costs are monitored and appropriately classified as capital or expense since the ongoing project costs will be substantial in subsequent years.

*Management response*

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Management agreed with the finding and established a process to capture all capitalized payroll through the payroll system.

*Resolution Status*

During Fiscal Year 2015, the Corporate Comptroller's office had implemented a coding system to be used on the payroll time sheets for those employees who were identified as working within implementation stages of the electronic medical record system. Upon submission of their time sheets, each must use a pre-designated code within one of the columns on the time sheet; which also must match up to an activity log which is accumulated by the Corporate Comptroller's Enterprise I.T. Services has also suggested improvement on data collection via the use of alternative programming and a SharePoint web service to collect same data for the future. This programming is near completion, and will be used for the remainder of this project as well as for other projects whereby payroll costs can be capitalized.

**Account Analysis Received from Other Departments**

*Observation*

Management routinely receives account analysis from other departments in order to update and adjust the financial records. During our review of the pollution remediation accrual account analysis, we noted that the accrual was recorded in the general ledger system inappropriately and resulted in an overstatement of the accrual by approximately \$56 million. In addition, management also identified an overstatement related to recording of pool payments as revenue that pertain to fiscal year 2015. Management subsequently adjusted the financial statements for the errors identified as a post-closing adjustment.

*Recommendation*

We recommended that management develop policies and procedures to ensure that account analysis from other departments are reviewed by the appropriate department supervisor and that a detailed analytical review is performed by an individual other than the preparer of the analysis.

*Management response*

Accounting staff have been trained to review external account analyses more critically. Knowledge of area undergoing the review will be focused on so staff can more readily recognize errors or inconsistencies with account analyses. Additional training has begun on fundamentals of testing data for inaccuracies. Training will continue commensurate with level of experience.

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*Resolution status*

Inclusive of the additional training and notice that the accounting staff has received in response to reviewing external calculations and materials received, the Comptroller's office has also designed a template in which those that "touch" the documentation at each level of review must sign off on the document prior to forwarding it for further review. This level of review further ensures that calculation errors and other omissions are caught prior to acceptance and final sign-off.

We continue to recommend that management improve the review and communication process between various departments and the finance department. We refer you to the observation above pertaining to reimbursement.

**Centralization**

*Observation*

The Corporation can potentially be enhanced through centralization and system integration. Currently, the Corporation has several functions that are centralized which include Information Technology services, procurement, treasury management, financial statement preparation (including receivable valuation), managed care rate negotiation, reimbursement rate reviews, billing and other finance systems maintenance. Other functions within the Corporation that are decentralized and performed at the facility locations include accounts receivable billing, accounts payable, payroll, reimbursement, and budget management and reporting. We also noted that during fiscal year 2014, the Corporation has centralized its procurement function and has appointed a Chief Procurement Officer.

*Recommendation*

We recommended that the Corporation consider centralizing various functions. Moving towards a system of integration and centralization of functions such as accounting and accounts payable may enhance controls, reduce and contain costs, effectuate cross-training of employees, improve communication, reduce risk, and allow for effective decision making.

*Management response*

Management agreed that centralization of certain functions may result in cost savings for the Corporation. Management will conduct a study to determine the feasibility of centralized functions and the opportunities to reduce costs and encourage efficiencies. Best practices within the industry will be examined for possible implementation at the Corporation.

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*Resolution Status*

The Corporation's 20/20 vision to secure the essential role of the nation's largest public healthcare system is to focus on the continuing improvement of the patient experience and gaining market share. To this end, senior leadership has agreed a new organizational structure is needed to enable the individual facilities to be primarily focused on the patient experience. This includes phasing out our network organizational structure and reorganizing into three distinct system-wide functional groups – Inpatient Care, Ambulatory Care, and Long Term / Post-Acute Care.

Additionally, centralizing certain functions out of the facilities into the corporate office (or other) is being reviewed as a way to streamline operations that are not patient centered; thereby allowing facilities to concentrate on the patient experience.

The Finance division will be impacted in these centralization efforts and has created a new department within the Corporate Comptroller's office, the Business Process Improvement Unit, which has been tasked with coordinating the strategic plans on the consolidation of various finance functions within the Corporation. Discussions will ensue during the last quarter of calendar year 2015 and will continue as needed.

**Vendor Listing**

*Observation*

The Corporation routinely hires full time independent contractors, such as temporary nurses, doctors and experts who provide service to the Corporation. During our test work, KPMG identified fourteen employees at various facilities who were independent contractors and were subsequently hired by the Corporation but remained on the vendor listing.

*Recommendation*

We recommended that management institute policies and procedures to ensure that these individuals are removed from the vendor listing timely prior to the beginning of their employment in order to eliminate potential duplicate and erroneous payments and employee fraud.

*Management response*

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Management agreed with the recommendation and has implemented a policy and process to ensure that any new employees be reviewed against the active vendor list and if identified on the vendor listing that they be deactivated.

*Resolution Status*

HHC Corporate Human Resources division will provide to the Supply Chain Services division on a monthly basis listing of all new Employees (Corporate Wide) which will be matched against the active vendor list. Supply Chain will inactivate any vendors in which there is a positive match, and log will be maintained documenting each monthly match date and each inactivation.

**Site Visits**

**Goldwater Movable Equipment Disposal**

*Observation*

Subsequent to the closure of the Goldwater Facility, \$2.5M of the \$5.3M of equipment book value was distributed to the Henry J. Carter and Coler Memorial facilities. The remaining assets were transferred to various other facilities and disposed of completely. However, KPMG was unable to obtain a listing of these assets to verify their amounts and which facilitates the assets were transferred to.

*Recommendation*

We recommended management develop specific policies and procedures as it relates to the transfer of assets from/to other facilities. This process should ensure that there is accurate record keeping of assets transferred including specific characteristics such as tag number and item description.

*Management response*

Policies and procedures related to transfer of assets between facilities currently exist and processing is completed only at the Corporate Comptroller level. Changes are processed in the system after the required transfer forms have been submitted by the facilities. Prior to the audit, the facility began the process of transferring control of the fixed assets duties from Materials Management to the Finance Division, reporting directly to the facility's Controller to gain greater control of asset reporting.

The facility Controller has been working with the Corporate Comptroller's Office to disseminate these corporate-wide policies and procedures for the transfer of assets between facilities to staff

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members. In addition, the Corporate Comptroller's office will continue educational sessions with fixed asset staff members across the Corporation. The Facility Controller, in conjunction with the Fixed Asset Manager and the Facility's Materials Management Director, will periodically review for compliance when transfers occur.

*Resolution status*

With the completion in transferring departmental control from Materials Management to the Finance Department, existing procedures have been implemented to ensure compliance and consistency to include the preparation and approval of the Relinquishment Form. The Fixed Asset Manager will prepare and perform the physical observation of the equipment, reconciliation of the Fixed Asset Management Systems and reviewed by the facility Controller's Office. Education to ensure compliance on the process is ongoing with the Department Managers.

**Custodial Funds**

*Observation*

During our audit, KPMG noted that Kings County changed the policies and procedures relating to custodial funds without previous approval by the Corporation. This resulted in an incorrect accounting of the custodial funds of approximately \$700,000 which was not considered material to the financial statements.

*Recommendation*

Although the adjustment of \$700,000 was not material to the overall financial statements, we recommended that facilities request approval from the Corporation's Central Office prior to implementing any new accounting and policy changes.

*Management response*

Management agreed with the recommendation and will ensure prior approval is received from the Corporation's Central Office before the implementation of any new accounting and policy change.

*Resolution status*

Kings County has fully implemented the previously approved accounting policy as stated above where the custodial account will be utilized for recording all of the related transactions, effective November 1, 2014.

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**Fixed Assets**

*Observation*

KPMG identified one fixed asset at Coney Island Hospital which was inappropriately marked as received in the Other Than Personnel Services (OTPS) System as of March 31, 2014.

Prior to physically receiving the asset, the facility recorded the asset on its fixed asset system and began depreciation in order to pay the vendor.

*Recommendation*

We recommended that management implement controls and updated policies and procedures to address the process that should be followed when an asset is returned to a vendor and payments to vendors for an asset prior to its actual receipt.

*Management response*

Management recognized that this was an isolated instance due to Super Storm Sandy. Hospital policy is that the payment is not to be made until asset is received, installed and verified that is functioning in working order. Equipment had been previously received, but removed by the vendor in order to reconstruct the room designated for the equipment that was damaged by Super Storm Sandy. Since the equipment was housed by the vendor as a courtesy of the facility, the vendor required payment, and it was inadvertently recorded as a depreciable asset. The hospital's Controller worked with department heads and materials management to ensure that equipment not put into service is recorded as construction in progress rather than as a depreciable asset. The fixed asset liaison will work with material management in strengthening internal controls for the issuance of asset tag numbers and the recording of depreciable fixed assets.

*Resolution status*

:

The equipment in question has been received and in use since November 2014. Since the KPMG Management Letter Comment, the Controller's Office has implemented the following process regarding recording and paying for fixed assets. A Coordinating Manager on the Controller's Office staff was assigned an additional responsibility. The employee is responsible to ensure that the asset is delivered to the facility before payment to the vendor is processed. All invoices pertaining to fixed assets are forwarded to the Controller's Office. The Coordinating Manager will coordinate with the department to inspect the asset in its assigned location. It is Coney Island Hospital policy to tag all movable assets regardless of the cost, and tag fixed assets when it is within reach and could be tagged. Upon inspection of the asset, the Coordinating Manager will place a hospital's asset tag and records the tag number, asset location and serial number if applicable on a copy of the purchase order. The department's representative is responsible to

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confirm the receipt by signing the invoice. This information is forwarded to the Material Management personnel for entering into OTPS system. After the asset is recorded in OTPS, Accounts Payable will process a payment to the vendor.

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**Industry Comments**

***Convergence in Healthcare\****

Over the last decade, the U.S. healthcare system has been redefining itself. What we know is that the current system is unsustainable, does not always deliver the highest standard of care, and is disjointed. As such, healthcare organizations should be thinking beyond healthcare transformation and focus on healthcare convergence with initiatives, such as HHC's 20/20 Vision Plan. While transformation of current operations is likely going to be a business requirement, the real question for forward looking organizations is what role they plan to play in a new and more converged health system. Today's transformation is inward looking – assembling the component parts, experimenting with new payment models, monitoring employer and consumer trends, understanding the role of new entrants and presenting a consistent and unified brand. Tomorrow's transformation will be defined by collaborating with others, such as providers, payers and life science companies, coordinating care across the continuum, becoming more patient centered and developing extended operating models, which is called Convergence.

Healthcare convergence will offer leading organizations new ways to grow revenue, reduce costs, manage risk and deliver quality care through one strong integrated healthcare system. There are already signs of Healthcare convergence that are steadily beginning to affect organizations, such as HHC which include: volume declines and new metrics, health insurance exchanges coming online, reimbursement reductions and governance questions on the linkage of strategy, risk and liquidity concerns. As healthcare convergence evolves, organizations need to be aware of various risks that need to be managed which include:

- Acknowledging margin compression and working capital needs
- Evaluating the opportunity to disrupt or the risk of being disrupted given the velocity of local market changes, including physician and other provider alignment
- Preparing for revenue transformation as new revenue streams emerge around public and private exchanges, narrow networks, and other value-based arrangements
- Understanding the payer response and monitoring employer and consumer attitudes/acceptance
- Evaluating “make or buy” decisions on the necessary tools, technology, and talent to operate in a risk-based environment
- Becoming agile around cost structures given declining volumes coupled with clinical transformation
- Conducting scenario planning, predictive modeling, and war gaming around market transformation and the impact on financial performance
- Assuring the integrity of clinical reporting and developing new metrics for the transition from volume to value
- Converting unstructured data into information for decision making to enable clinical, operational and financial benchmarking across the continuum of care along with real-time predictive clinical surveillance systems

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- Managing increasingly complex compliance regimes and enhancing transparency in reporting

In addition, health reform initiatives, such as DSRIP will require hospitals and physicians to examine their historical relationships and align around patient-centered care and shared financial gain.

Overall, organizations will need to see convergence at a strategic level to create new models and incentives; convergence at a system level to integrate data and IT; convergence at the patient level to deliver an integrated model of care; and convergence at the ecosystem level to ensure best practices and new approaches are tested and results shared as one strong healthcare system.

**New York State’s Delivery System Reform Incentive Payment (DSRIP) Program \***

DSRIP is the main mechanism by which New York State Department of Health (“DOH”) will implement the Medicaid Redesign Team (“MRT”) Waiver Amendment. DSRIP’s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the ultimate goal of reducing the cost of care, while improving the quality and access to care provided. Up to \$6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health over a 5 year period.

The 5 year DSRIP period began April 1, 2015. During the 5 year DSRIP period, DSRIP payments based upon achieving predefined results in system transformation, clinical management and population health. The payments to be made are based upon performance against pre-defined milestones and outcomes – failure to meet milestones and reporting requirements may result in a reduction to the payments or, in some instances receiving no payment.

Each PPS “Lead” entity has entered into a contract with DOH under which the PPS Lead is responsible for ensuring that the PPS complies with and implements the terms contained in its DSRIP Application and its formal implementation plan. The PPS Lead has also agreed, as part of its role, to ensure that the PPS complies with the terms and conditions of the governing agreements between the DOH and CMS of the 1115 Waiver and the Terms and Conditions.

There are several risks associated with any program of this size and complexity that Management should consider. These include, but are not limited to the following:

- During the DSRIP period, PPS leads will be making Medicaid payments to their network partners in connection with their DSRIP project implementation and performance plans and targets. Therefore, PPS Leads are directed by DOH/OMIG to dedicate resources

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toward implementing a compliance program that will assist in preventing and identifying Medicaid payment discrepancies related to DSRIP payments.

- The PPS Lead is responsible for the meeting the PPS' reporting requirements, which includes submission of claims and other data to DOH by the network providers as well as specific additional reporting that must be submitted by the PPS Lead. DSRIP payment to the PPS is based upon this data. There is risk that the data from participating providers in the PPS is not provided in a timely manner, or lacks the integrity and accuracy warranted.
- Each DSRIP year begins April 1 and ends March 31 of the subsequent calendar year. During this 12 month period the PPS Lead is responsible for completing quarterly and semi-annual reporting that is required under DSRIP to be submitted to DOH for evaluation and scoring.
- The PPS Lead must establish a funds plan that defines how DSRIP payments that are received will be distributed to the network partners and how those funds might be utilized by the PPS lead to meet certain administrative requirements and costs. There is risk that the PPS does not meet all of the reporting or performance requirements and that the payment to the PPS may be reduced.
- PPS funds may be reduced if the State's overall DSRIP PPS performance does not meet statewide benchmarks for certain measures.
- Audits may be performed to validate submissions and performance metrics. Funds may be subject to recoupment or recovery based upon internal review or audit if it is determined that funds are willfully misused and/or the information relied upon for payment purposes was in error, misreported, or if DOH made an error in determining the payment.

The DSRIP program represents a significant opportunity to effect fundamental change in New York's healthcare delivery system, as well as a funding opportunity for individual providers to prepare themselves to serve their communities more effectively in the next era of healthcare delivery.

It is critical for the management and board of the Corporation to be engaged in the process and understand the risks and benefits so they can effectively steer the organization through the changes to come.

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**Cyber Security**

Cyber Security is an important concern for every organization. Daily occurrences including the recent cyber-attack at Anthem Blue Cross Blue Shield, demonstrates the risk posed by cyber attackers, from individual, opportunistic hackers, to professional and organized groups of cyber criminals with strategies for systematically stealing intellectual property and disrupting business. Management of any organization faces the task of ensuring that its organization understands the risks and sets the right priorities. This is no easy task in light of the technical jargon involved and the pace of change.

Focusing on technology alone to address these issues is not enough. Effectively managing cyber risk means having in place the right governance, the right supporting processes, along with the right enabling technology. It is essential that organizations deal with cyber security, actively manage governance and decision making over cyber security, and build an informed and knowledgeable organizational structure.

Organizations can reduce risks to their businesses by building up capabilities in three critical areas: prevention, detection and response.

- **Prevention:** begins with governance and organization. It is about installing fundamental measures, including placing responsibility for dealing with cybercrime within the organization and developing awareness training for key staff.
- **Detection:** through monitoring of critical events and incidents, an organization can strengthen its technological detection measures. Monitoring and data mining together form an excellent instrument to detect strange patterns in data traffic, to find the location on which attacks focus and to observe system performance.
- **Response:** refers to activating a well-rehearsed plan as soon as evidence of a possible attack occurs. During an attack, the organization should be able to directly deactivate all technology affected. When developing a response and recovery plan, an organization should perceive cyber security as a continuous process and not as a one-off solution.

KPMG recommends that the Corporation determine if they have an adequate approach to cyber security and if preparations for a security event and the ability to prevent or minimize the impact of an event has been addressed.

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**Data Analytics \***

Healthcare organizations are challenged by pressures to reduce cost, improve coordination and outcomes, provide more with less and be more patient centric. Data Analytics can help healthcare organizations create actionable insights, improve outcomes and reduce time to value. Data Analytics will define the way business and organizations operate in the future.

Data Analytics offers breakthrough possibilities for new research and discoveries, better patient care, and greater efficiency for health care organizations. Data Analytics could provide opportunities for healthcare organizations to improve internal operations in the areas of operating costs, resource management, identifying process or performance efficiencies, and identifying new business opportunities and ways to be innovative. Data Analytics can also drive improvements in care processes, delivery and management as well as support optimal revenue cycle performance and further achieve the organization's mission.

Healthcare organizations are increasingly using analytics to apply new insights from information. New methods of analytics can be used to drive clinical and operational improvements to meet business challenges. From a traditional baseline of transaction monitoring using basic reporting tools, spreadsheets and application reporting modules, analytics in healthcare is moving toward a model that will eventually incorporate predictive analytics, which take an understanding of the past to predict future activities and model scenarios using simulation and forecasting which will enable organizations to "see the future", create more personalized healthcare, and predict patient behavior. Analytics will enable the compilation of information about trends, patterns, deviations, anomalies and relationships and reveal insight.

Predictive modeling and analyzing data will be critical for an organization's continued success. A data-driven organization would be highly capable of using data to manage its exposure to risk, identify opportunities, and provide sharper insight into how their activities would impact top and bottom-line performance. Finance departments of organizations would no longer focus on analyzing why forecasts were missed and instead focus on providing insight on where the business can close the gap in order to meet or exceed upcoming financial goals. A fully embedded Data Analytics strategy would mean that businesses and employees look first to data to guide their actions. It is important that organizations be proactive instead of reactive in analyzing key metrics and information.

We recommend that the Corporations management team develop strategies, if not already done, to address the way they collect and analyze quality measurement data.

**NEW YORK CITY  
HEALTH AND HOSPITALS CORPORATION**

Matrix of Observations

June 30, 2015

**Disaster Readiness**

Disaster response and recovery and the respective programs in place at healthcare organizations have been recurring hot topics in the wake of Hurricane Irene, Hurricane Sandy, various snow storms, Ebola and other unforeseen circumstances. It is important for healthcare organizations to have efficient and effective disaster readiness and recovery programs and established processes and procedures in place. Such processes and procedures should include methods for management to track incremental expenses and labor costs that may be subject to recovery (i.e. Federal Emergency Management Agency Funds or insurance claims), and the impact of the business interruption to operating results.

Healthcare organizations should educate their respective personnel on disaster response and recovery, and monitor any incremental expenses and labor relating to these incidents if they should occur and track all revenue streams that are effected by the disaster.

**Creating New Value with Patients, Caretakers and Communities**

Healthcare organizations need to continue to work with patients, their caretakers, families and communities to improve value, safety, quality and potentially reduce costs. New skills, technology and approaches are required to do this. Being able to do this will be a differentiating factor for payers, providers and life science companies. The following next steps can assist healthcare organizations create new value with their patients, caretakers and their communities.

- Healthcare organizations spend most of their resources on developing interaction with their patients. In order for healthcare organizations to increase patients' activity, they need to review all of their interactions with them to ensure that each of them increases the capacity of patients to be more active in their own healthcare. At the end of a consultation, does the patient always leave with greater skills to self-manage than they had at the beginning of that consultation? Does every letter, email or phone call leave them with greater capacity to know what they have to do next? Are healthcare organizations checking up that these attempts at improving patient capacity actually work with the patients and are not just empty instructions from medical professionals that have no impact on behavior?
- Successful industries are those that encourage consumers to create value design for their products with those that consume them. Healthcare organizations need to fully involve their patients, their caretakers, families and communities in all healthcare redesign. Research shows that few patients think that happens at the moment.

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June 30, 2015

- The practice of most medical professionals is based upon seeing patients as a set of deficits. For medical professionals to recognize the possibilities of self-management and to see patients, their families and their communities as a set of assets is a departure from the deficit model. The workforce will need new technical skills to work with, a number of tools such as decision aids, telehealth and other self-care technology and with real-time information about patient experience. All of the components need to be built into recruitment, induction, appraisal and reward strategies.
- Payment systems will need to be reorganized to recognize the value creating possibilities of patients, their caretakers, families and the communities. Compared to most medical interventions, the investment in better patient self-management is not expensive, but still calls for some resources. If the payment system is organized in such a way as to see self-management as just another form of episodic cost, then it is difficult to see where the return on this investment comes from. If however, the payment system is organized to cover an entire patient pathway or population, the return on the investment in better patient self-management is potentially significant.

As HHC moves forward with their 20/20 strategic vision to become the provider of choice for many New Yorkers and improve patient experience, this strategic vision will create new value with the Corporations patients, caretakers and their communities

**Privacy\***

*HIPAA Compliance*

The Department of Health and Human Services recently finalized the Omnibus in January 2013, which modifies the existing Privacy, Security, and Breach Notification Rules under HIPAA and HITECH. The Omnibus will be effective in March 26, 2013, with a compliance date of September 23, 2013.

The Omnibus codified the compliance monitoring required by the Office for Civil Rights (OCR), which was initially put forth in HITECH. In response to HITECH, OCR established an Audit Program that was executed across covered entities across the country in 2012. OCR has indicated that the Audit Program will continue, with the next round of audits to include business associates.

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The Omnibus modifications represent significant changes to the Rules, particularly in the Privacy and Breach Notification Rule. Among the most significant changes brought forth by the Omnibus are the changes with respect to business associates and breach notification. The definition of business associates has changed to include a person or organization that creates, receives, maintains, or transmits protected health information (PHI) in the course of performing functions on behalf of a covered entity. Additionally, covered entities are now required to gain documented satisfactory assurances from the business associates regarding the safeguards for PHI.

The Omnibus further clarified the liability related to PHI and indicated that there is downstream liability. The requirements to safeguard PHI, adherence with the Security and Breach Notification Rule, and the terms agreed to in the business associate agreement run down stream to any vendor or subcontractor engaged by the business associate. Absent a business associate agreement, OCR has the authority to make the determination that a vendor is performing the functions of a business associate, thus imposing liability. Covered entities must perform a risk assessment of its vendors to adequately understand and mitigate potential risks.

The changes related to Breach Notification eliminated the threshold of harm standard. Previously, a covered entity engaged in a risk analysis to determine the significance of harm for any unauthorized access or disclosure of unsecured PHI to determine whether there was a significant risk of reputational, financial, or other harm, thus resulting in a breach. The standard has been lowered with the Omnibus, instituting a presumption of breach, unless a covered entity can demonstrate a low risk of harm based on factors identified by the Omnibus Rule.

There are also other changes to access to PHI, marketing, fund-raising, the definition of PHI, genetic information, deceased individuals, and research; all changes will require updates to the Notice of Privacy Practices as necessary and appropriate consistent with the requirements.

Under the Omnibus, penalty levels have been increased for noncompliance. Penalties are increased for noncompliance based on the level of negligence with a maximum penalty of \$1.5 million per violation. In addition to monetary fines, noncompliant covered entities may be subject to loss of contracts, criminal and civil investigation, federal and state fines, cost of breach notification, and reputational risk.

As technology becomes further integrated with the delivery of care through medical records, sharing information on smart phones, texting, and cloud technology (see additional comments), we recommend that the System revisit its HIPAA compliance program to ensure that the organization is able to comply with the recently enacted HIPAA regulations. Healthcare organizations should consider the following:

- Does the organization engage in an annual documented HIPAA risk assessment of both the Security and the Privacy Rule under §164.308(a)(1)(A)?

**NEW YORK CITY  
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Matrix of Observations

June 30, 2015

- Does the organization know where all of its PHI is, including software, legacy systems, mobile devices, and unstructured data?
- Does the organization have controls in place to identify all vendors requiring a business associate agreement and to understand the information being disclosed to the vendors and by whom in the organization?
- What is the organization's plans to update its key HIPAA documentation and practices with respect to the Omnibus?
- The organization started to implement a certified meaningful use system; has the organization updated its risk assessment to meet meaningful use criteria?

*Electronic Personal Health Information*

The growing use of mobile devices in healthcare increases the risk to healthcare organizations that the security of their patient ePHI (electronic personal health information) could be breached. As such, healthcare organizations need to develop strategies to protect all ePHI accessed, stored, or transmitted via smart phones and tablets. This strategy may include a mobile security risk assessment, establishment of policies and procedures regarding mobile access, patient consent, and data storage on mobile devices, including encryption, transmission to and from mobile devices, and training programs, and implementing measures to prevent unauthorized access.

\* \* \* \* \*

We would be pleased to discuss these comments and recommendations with you at any time.

The Corporation's written responses to our comments and recommendations have not been subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

This communication is intended solely for the information and use of management, the Audit Committee, others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

Very truly yours,

[ (signed) KPMG LLP ]



**AUDIT COMMITTEE OF THE  
HHC BOARD OF DIRECTORS**

**Corporate Compliance Report  
December 1, 2015**

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

Background

1) NYC Health + Hospitals Corporation (“H + H” or 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 (see subdivision 3 of this section, *infra*, for further details). In carrying out its records management program responsibilities, NYC Health + Hospitals has committed itself to, in pertinent part, the following:

- (i) 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;
- (ii) assessing the value of any record prior to determining its disposition; and
- (iii) encouraging the systematic disposal of unneeded records.

Overview of Current Volume of Records Stored Offsite

2) In addition to records that are stored at each facility, 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.

A sample breakdown of the number of boxes currently stored by facility with Recall includes the following:

- Bellevue Hospital Center (51,666);
- Coler Specialty Hospital and Nursing Facility (3,217);
- Coney Island Hospital (32,112);
- Cumberland Diagnostic & Treatment Center (10,429);
- Elmhurst Hospital Center (31,900);
- Gouverneur Nursing Facility and Diagnostic & Treatment Center (4,425);
- Harlem Hospital Center (30,149);
- Jacobi Medical Center (44,359);
- Kings County Hospital Center (67,082);
- Metropolitan Hospital Center (32,506);

- Queens Hospital Center (31,055);
- Woodhull Medical and Mental Health Center (63,997);
- North Central Bronx Hospital (15,562);
- Lincoln Medical and Mental Health Center (67,676);
- Renaissance Diagnostic & Treatment Center (5,712);
- Home Health Care (4,561);
- East New York (3,174);
- Morrisania Diagnostic & Treatment Center (7,195)
- Central Office (16, 040)
- MetroPlus (7, 382)

### Regulatory Requirements

3) Pursuant to § 57.25[2] of Article 57-A of the New York Arts and Cultural Affairs Law (“Local Government Records Law”), no officer of a public benefit corporation – including H + H, may destroy or otherwise dispose of a record without the consent of the Commissioner of the New York State Education Department (the “Commissioner”). To implement this requirement, the Commissioner, pursuant to 8 NYCRR §§ 185.4(b) and 185.5[c], has consented to the disposition of records held by local government public benefit corporations provided that such disposition is in accordance with the New York State Records Retention and Disposition Schedule found at 8 NYCRR 185.14 (Appendix “K”)(the “Schedule”) (1988; rev.2006) and such schedule is approved by formal resolution of the System’s governing board.

4) To meet the aforementioned requirements and to establish a record retention schedule consistent with the requirements of the State statute, the Office of Corporate Compliance (“OCC”), in consultation with the Office of Legal Affairs (“OLA”), amended OP 120-19, which as stated above governs retention of records to meet State requirements. Moreover, as required by 8 NYCRR §§ 185.4(b), the revised OP 120-19 was approved, on June 12, 2014 by the Audit Committee of the NYC Health + Hospitals Board of Directors and, on June 26, 2014, by the NYC Health + Hospitals Board of Directors.

5) The revised OP 120-19 is posted on the NYC Health + Hospitals web site and its implementation provides in-depth guidance to the NYC Health + Hospitals workforce on the retention requirements for H + H’s documents and records.

### Recent Facility Requests to Destroy Records

6) In 2015, representatives from the Metropolitan Hospital Center (“Metropolitan”) and the Gouverneur Healthcare Services (“Gouverneur”) requested authorization from the NYC Health + Hospitals Records Management Officer to destroy certain documents

and patient records maintained at their facilities due to water damage incurred to said records as a result of Hurricane Sandy. Based on the requirements to destroy records under State law, these requests to destroy records were denied by the NYC Health + Hospitals Records Management Officer.

7) Authorization to destroy documents and records that have not met the State's retention requirements mandates that H + H, pursuant to Arts and Cultural Affairs Law § 57.25(2), first obtain the consent of the Commissioner before such records may be destroyed. More specifically, State law requires local governments – such as H + H - to apply to the Commissioner to dispose of records whose retention periods have not expired in cases where those records have been “damaged by natural or manmade disaster, and when the information contained in those records is substantially destroyed or obliterated or the records constitute a human health or safety risk. Those records may be disposed of following application to the commissioner and *after the consent of the commissioner has been granted.*” 8 NYCRR § 185.6(b) (emphasis added).

8) In seeking authorization to destroy records, Metropolitan and Gouverneur are tasked with providing the OCC with objective information that the records are non-salvageable and present a health hazard. Notwithstanding the likely validity of the facility's claims, the State Department of Education will require evidentiary support for their assertions including, most likely, the assessment of an environmental expert, or some such equivalent, who will examine the damaged records and make a finding as to whether the records were “substantially destroyed or obliterated or ... constitute[d] a human health or safety risk.” 8 NYCRR § 185.6(b). If a finding of substantial damage or health hazard is made, a certification to that effect from the expert can be combined with our application to the Commissioner requesting his/her approval to destroy the identified records.

- Note: Moving forward, the OCC will work with Metropolitan and Gouverneur to facilitate the necessary processes and steps required before an application to the Commissioner can be submitted to destroy the affected records.

### The Loss of Records to Fire at the Recall/CitiStorage Facility

#### *The Fire*

9) On January 31, 2015, a fire destroyed the Recall/CitiStorage facility located at 5 North 11th Street, Brooklyn, New York (the “North Building”). At the time of the fire, approximately 1 million boxes of assorted files and records belonging to more than 2,000 Recall/CitiStorage clients, including HHC, were stored in the North Building.

10) At 4:30 a.m. on January 31, 2015, the Recall/CitiStorage fire detection system and sprinkler systems was triggered by a small fire in the North Building. The fire detection system automatically communicated with local fire authorities and activated sprinklers in the affected zone. The fire department arrived quickly in response to the alarm and extinguished the fire with minor damage to the stored material and no damage to the building. With the fire extinguished, the fire department deactivated the sprinkler system to stop the flow of water onto the stored boxes and left the premises.

11) The OCC was informed that, approximately one hour after the departure of the fire department, and before the sprinkler system could be reset, the fire rekindled into a far larger fire. Responding fire fighters fought the second fire that fully engulfed the North Building and did so in adverse weather conditions that included ice and freezing rain. Because the combustible material in the stored boxes fueled the fire, and because the flames were fanned by the weather conditions, it was more than a day before the fire was finally declared under control and days later before the fire department finally stopped pouring water onto the site. By the time that the fire was declared extinguished, the North Building was totally destroyed and, along with it, 965,032 stored boxes of files and records.

*The Mitigation Effort*

12) With the fire ongoing, Recall/CitiStorage engaged Belfor Property Restoration (“Belfor”), an experienced disaster recovery and property restoration company, to mitigate the impact caused by the event. As part of an effort to mitigate record loss and to prevent the unwanted dispersal of those records, Belfor employed three boats on the East River to retrieve loose records by using nets and extension grabbers. On land, Belfor employed crews wearing waterproof protective equipment to walk on the East River shoreline to retrieve loose documents by hand. Following a protocol that ensured a chain of custody for recovered damaged documents and records, Belfor gathered the material to review as to whether it could be salvaged and, if not, to arrange for its permanent disposal in a landfill.

- NO FURTHER TEXT ON THIS PAGE -

**NYC  
Health +  
Hospitals**

**OFFICE OF CORPORATE COMPLIANCE**

**AUDIT COMMITTEE OF THE  
HHC BOARD OF DIRECTORS**

Corporate Compliance Report  
125 Worth Street  
5th Floor Boardroom, Room 532  
New York, NY 10013

Tuesday, December 1, 2015 @ 1:00 p.m.

*The Impact of the Fire to NYC Health + Hospitals*

13) As a result of the fire, NYC Health + Hospitals lost 144,019 boxes of stored material in the North Building that included, among other things, patient medical records, personnel information, payroll records, and x-rays. The Facility breakout for lost boxes is as follows:

<u>FACILITY</u>	<u>STORED BOXES DESTROYED</u>
BELLEVUE	11,776
COLER	952
BELVIS	219
CARTER	343
CONEY ISLAND	16,067
CUMBERLAND	794
EAST NEW YORK	223
ELMHURST	8,334
GOUVERNEUR	403
HARLEM	9,523
JACOBI	26,188
KINGS	10,263
LINCOLN	14,509
METROPOLITAN	4,223
MORISANIA	468
NORTH BRONX	4,152
QUEENS	24,583
RENAISSANCE	2,363
WOODHULL	3,632
HOME HEALTH CARE	964
CENTRAL OFFICE	643
METROPLUS	1,081

- There were Additional NYC Health + Hospitals boxes from Cook and Chill Health Services, Bushwick, Neponset and Washington Heights destroyed at the site that are not represented in the above count.
- A Certificate of Destruction has been issued by Recall to NYC Health + Hospitals identifying and attesting to the specific files that were lost in the fire. To be used when receiving requests for destroyed records, copies of this certificate have been provided to HIM Directors and the Risk Management Offices of all affected facilities.

### Long-Term Record Management Plans

14) The NYC Health + Hospitals Records Management Officer will work with Enterprise Information Technology Services (“EITS”) to identify and acquire a records management software program that will enable, among other things, the H + H records management program to: (i) inventory and categorize NYC Health + Hospitals records from the time such records are conceived through to their eventual disposal (this 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.

- It is necessary that any selected program provide features that will (i) permit the inventory and management of the locations and contents of corporate-wide folders and boxes of records; (ii) track the movement of folders and boxes of records; (3) capture and manage requests for records or records series; (4) offer a data base for the monitoring, control and recording of the destruction of records; (5) offer a filing and indexing system for forms requesting the retrieval or destruction of records; (6) offer a storage and management system for inactive records that identifies records as they become subject to destruction; (7) 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; (8) meet the record life cycle requirements of H + H OP 120-19; (10) permit the generation of standard reports that print out as they are seen on the screen; and (11) offer functionality that will permit the generation and use of customized forms, correspondence and other records. The OCC and EITS will be present the aforementioned request at the next Records Retention Council (“RRC”) scheduled for December 2015, as required under Department of Education regulations, for discussion and approval as to concept and need.

15) As required under OP 120-19, each facility is in the process of appointing facility records management officers (“FRMOs”) to identify 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.

Overview of City Storage Contract/Key points

16) The following is an overview of some of the key points of the City Storage/Recall Contract

- CitiStorage has had multiple contracts with NYC Health + Hospitals since the mid-1990s. The current contract began on April 1, 2014 and runs for three years.
- The contract is a fixed rate contract at a per box/per month price covering storage and regular services. NYC Health + Hospitals pays for the number of boxes it stores up to a cap of 550,000 boxes. Although H + H is presently above the cap, H + H is being charged only at the cap rate.
- *Current Cost - \$310,750 per month plus the purchase of boxes and any projects.*
  - Did this cost go down after the fire? No. The cost did not go down post fire because prior to the fire NYC Health + Hospitals was storing over 700,000 boxes but being charged only at the cap rate for 550,000 boxes. NYC Health + Hospitals is currently storing over 577,000 boxes and the numbers are reportedly increasing. It is only if H + H drops below a total of 550,000 boxes will costs begin to go down.
  - Are there any long term services (digitization, micro-fiche etc.) that the Recall is negotiating with NYC Health +Hospitals? There had been preliminary internal conversations between Recall and Joe Quinones, H + H Senior Assistant Vice President, Contract Administration and Controls, to expand into digital services and information governance but there are no current negotiations going on. The vendor represents that they have a complete digital services division that works with customers to handle back file conversions, business process automation, enterprise content management & information governance. This subject will be discussed at the next RRC meeting.

## **II. Excluded Providers**

- 1) There are no reports of excluded providers (HHC Workforce Members, contractors, etc.) with regard to the NYC Health + Hospitals Acute Care, Long Term care, and Ambulatory Care sites.
- 2) There was an excluded provider with regard to a possible DSRIP partner.
  - In October, during its exclusion review process, the OCC learned that a physician and the Article 28 health clinic that he represented in his proposed DSRIP affiliation with H + H's wholly owned subsidiary OneCity Health, were excluded by the New York State Office of the Medicaid Inspector General from participation in the State's Medicaid program. The subject physician was one of two owners of the Article 28 health clinic (which consisted of four owners in total) who were among 23 defendants named in a 199-count indictment handed down by a Kings County Grand Jury in March 2015. The indictment alleged, among other things, the defendant's participation in a massive scheme in which they lured potential patients recruited from low-income neighborhoods, homeless shelters and welfare offices to medical clinics for unnecessary tests and procedures with promise of gifts (e.g., free footwear). The aforementioned two owners of the Article 28 health clinic, as well as the Article 28 health clinic, were excluded from participation in Medicaid.
  - Christina Jenkins, M.D., OneCity Health's Executive Director, confirmed that no DSRIP payments were made to the subject excluded physicians or the Article 28 health clinic that they were affiliated with. Dr. Jenkins further confirmed that H + H/OneCity Health has not signed a DSRIP agreement with the subject Article 28 health clinic. This matter is being further looked into by H + H/OneCity Health and the OCC. Note, the Article 28 health clinic in question is no longer excluded from the Medicaid program.
- 3) The OCC is presently reviewing NYC Health + Hospitals employees who provide prison health services as it relates to the exclusion checks.

## **III. OCC Staffing Plan**

- 1) The OCC Senior Assistant Vice President/Chief Corporate Compliance Officer Wayne A. McNulty is finalizing the OCC staffing plan for FY16 for approval by H + H President & CEO Ramanathan Raju, MD. The revised OCC's staffing plan will reflect the System's reorganization vision as current staffing resources will be redistributed to facilitate a greater focus on ambulatory care and long term care. Additionally, compliance

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officers will focus on geographic regions (e.g., Bronx, Brooklyn, Queens, and Manhattan) with regard to acute care compliance activities. The staffing plan includes compliance officer positions to cover Gotham Health FQHC<sup>1</sup> (.4FTE), the HHC ACO, Inc. (.4FTE), and OneCity Health/DSRIP (1.0 FTE) compliance-related activities.

#### **IV. National Government Services (NGS) reviews**

1) NGS has contacted the OCC regarding several claims denials. The OCC is working with Revenue Management to investigate and address these matters. A detailed report of the same will be provided to the Audit Committee once said review and investigation is completed. There are no apparent overpayment issues as the NGS reviews pertain to claims denials.

#### **V. HHC ACO, INC., Compliance Activities – Update**

##### Background of the HHC ACO, Inc.

##### *Formation of HHC subsidiary to carry out accountable care activities*

1) As previously reported to the Audit Committee in June 2015, the HHC ACO, Inc., a wholly owned HHC subsidiary, was selected by CMS to participate in the Medicare Shared Savings Program (MSSP) for a three-year term that began on January 1, 2013.<sup>2</sup> Under the MSSP, the ACO is accountable for improving the quality of care for approximately 13,000 Medicare fee-for-service beneficiaries who receive primary care at HHC.

##### *HHC ACO, Inc. participants*

2) As of June 2015, the following entities and their employed providers will perform functions or services related to the ACO's activities:

- Coney Island Medical Practice Plan, P.C.
- Downtown Bronx Medical Associates, P.C.
- Harlem Medical Associates, P.C.

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<sup>1</sup> Gotham Health is a family of NYC Health + Hospitals neighborhood health centers

<sup>2</sup> On June 12, 2012 the HHC Board of Directors by way of resolution approved the formation of HHC ACO, Inc. ("HHC ACO"), a wholly owned subsidiary public benefit corporation in order to establish an Accountable Care Organization to meet the purposes and goals of the Medicare Shared Savings Program. The following individuals have since been designated to key leadership roles at HHC ACO: (i) the Chief Executive Officer of the HHC ACO is Ross Wilson, M.D., who also serves as HHC's Senior Vice President, Quality/Corporate Chief Medical Officer; (ii) the Medical Director of the HHC ACO is Nicholas Stine, M.D.; and (iii) the Director of Operations of the HHC ACO is Megan Cunningham

- Icahn School of Medicine at Mount Sinai  
Icahn School of Medicine at Mount Sinai, doing business as  
the Mount Sinai Elmhurst Faculty Practice Group
- Metropolitan Medical Practice Plan, P.C.
- New York University School of Medicine
- NYC Health & Hospitals Corporation
- Physician Affiliate Group of New York, P.C.

### Overview of Accountable Care Organizations

3) Pursuant to the Patient Protection and Affordable Care Act (“PPACA”), “the Centers for Medicare & Medicaid Services (CMS) finalized the Medicare Shared Savings Program (MSSP) .... to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through [ACOs].”<sup>3</sup> “ACOs are groups of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that agree to work together to coordinate care for the Medicare Fee-For-Service patients they serve.”<sup>4</sup> The goal of an 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. This improves patient outcomes and reduces overall cost of care.<sup>5</sup>

4) ACOs create incentives for health care providers to work together to treat an individual patient across care settings—including doctor’s offices, hospitals, and long-term care facilities.<sup>6</sup>

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<sup>3</sup> (CMS Accountable Care Organization 2014 Program Analysis Quality Performance Standards Narrative Measure Specifications, June 30, 2014, prepared by RTI International, accessed at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf>)

<sup>4</sup> *Id.*; see also 42 CFR §425.10 and 42 CFR § 425.20

<sup>5</sup> See <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html>, (last accessed on June 8, 2015); see also 42 CFR § 425.10.

<sup>6</sup> The Goals of an ACO are to: (i) “deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a Fee-For-Service payment system in which different providers receive different, disconnected payments”; (ii) maintain “a patient-centered focus . . . .”; and (iii) develop “processes to: (a) promote evidence-based medicine; (b) promote patient engagement; (c) internally and publicly report on quality and cost; and (iv) and coordinate care. (CMS Accountable Care Organization 2014 Program Analysis Quality Performance Standards Narrative Measure Specifications, *supra*, note 16)

Achievement of Quality Performance Standard

5) ACOs cannot share in savings unless the quality performance standard for that year is realized. The 2014 ACO quality standard consists of 33 quality measures, which can be separated into four key categories:<sup>7</sup>

- Patient/caregiver experience - 7 measures;
- Care coordination/patient safety - 6 measures;
- At-risk population - 5 measures and 2 composites consisting of an additional 7 measures; and
- Preventive Care – 8 measures.

The HHC ACO's Participation in the Medicare Shared Savings Program ("MSSP")

6) The HHC ACO participates in the MSSP. Although the HHC ACO currently focuses on Medicare fee-for-service patients, the HHC ACO will drive broader transformation to a higher-performance health system, serving and ultimately benefiting all HHC patients.

Receipt of Warning Letter from the Centers for Medicare and Medicaid Services

7) On October 9, 2015, Centers for Medicare & Medicaid Services ("CMS") issued a Warning Letter to HHC ACO senior management, with a copy to the NYC Health + Hospitals Office of Corporate Compliance, providing that the HHC ACO failed to meet the requirements of the MSSP quality measures in each set domain (the "Warning Letter"). Specifically, in the Warning Letter, CMS asserts that HHC ACO failed to achieve the required minimum attainment level on 70 percent of the pay for performance measures in one of the four quality domain areas. The Warning Letter also provides that continued poor performance or failure to meet the quality performance standard in the future may result in termination of the HHC ACO.

8) CMS requires ACOs to exceed the minimum performance threshold on 70% of the pay for performance measures within each of four domains. HHC ACO exceeded the minimum performance threshold on 29 of the pay for performance measures, and according to CMS, its overall quality performance was ranked in the 76th percentile. However, HHC ACO failed to exceed the minimum performance threshold on 4 of the performance measures.

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<sup>7</sup> *Id.*

9) Three of the quality measures that HHC ACO failed to meet were in the Care Coordination/Patient Safety domain, which consists of 6 quality measures. Thus, for the Care Coordination/Patient Safety domain, which has 6 pay for performance measures in total, HHC ACO did not exceed the minimum threshold for more than 70 percent of the performance measures, and the Warning Letter was issued. Within the Care Coordination/Patient Safety domain, the ACO failed to exceed the minimum threshold for the following performance measures:

- (1) Ambulatory Care Sensitive Admissions for Chronic Obstructive Pulmonary Disease (“COPD”) or Asthma
- (2) Ambulatory Care Sensitive Admissions for Heart Failure
- (3) Percent of Primary Care Physicians (“PCPs”) who Qualified for Electronic Health Records (“EHR”) Incentive Payment (the only double-weighted performance measure)

CMS Required Corrective Action Plan

10) CMS requires HHC ACO to take the following actions:

- The HHC ACO should institute policy and process changes to prevent failures to meet performance standards; and
- To review the CMS ACO Spotlight for information regarding ACO trainings.

Management’s Response – HHC ACO, Inc.:

*Quality Performance Considerations*

11) Although HHC ACO’s overall 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 documentation of Meaningful Use execution.

12) More particularly, 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 Electronic Health Record 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.

*Corrective Action Plan*

13) The HHC ACO takes the improvement of its performance very seriously, and has been aware of and focused on these outlier performance areas since CMS first began providing performance data in August 2014. The corrective actions that are planned or already underway to address measure deficiencies are described below.

- 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.

- *Percent of PCPs who Qualified for EHR Incentive Payment*
  - HHC 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. HHC made a concerted effort to satisfy program requirements in 2014; unfortunately, EP attestation was not completed in time to meet the MSSP measure deadline.
  - HHC 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, HHC will prioritize primary care providers that are likely to be in the MSSP measure denominator.
  - Based on requirements set forth in Centers for Medicare & Medicaid Services (CMS) guidelines for MU2 Eligible Professionals, a prerequisite was required for H+H to deploy e-prescribe to satisfy the MU2 EP requirements. Over the last 8 months H+H has focused on the prerequisites and successfully deployed e-prescribe throughout the H+H environment while upgrading all Quadramed 8 independents environments to satisfy the CMS certified EMR requirement. With all prerequisite satisfied H+H is now in a position to attest for the MU2 CMS Eligible Professional benefit in the last calendar quarter of 2015. Working with Medical and Professional Affairs and Finance, a plan has been established to meet the CMS attestation requirements for 51% of H+H Eligible professionals to attest over a consecutive 90 day period starting in October 2015 and ending in December of 2015.

OCC Follow Up

14) The OCC will follow up with the Office of Legal Affairs to determine if there are any potential overpayments to address here, which at this juncture appears to be unlikely. The OCC has requested that HHC ACO administration copy the OCC on all

future performance reports and related documents sent to and received from CMS. Moving forward, the OCC will monitor and validate that the above mentioned corrective action plans are met and will report on the same to the Audit Committee in February 2016.

## **VI. Privacy Incidents and Related Reports for the Third 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 Protected Health Information (“PHI”).

### Reportable Privacy Incidents for the Third Quarter of Calendar Year 2015 (July 1, 2105 to September 30, 2015 – hereinafter “3rd Quarter”)

2) During the 3<sup>rd</sup> quarter, twenty-one (21) complaints were entered in the ID Experts RADAR (HIPAA Incident Tracking) System. Of the 21 complaints entered in RADAR, seven (7) were found to be violations of NYC Health + Hospitals HIPAA Privacy Operating Procedures; three (3) were determined to be unsubstantiated; five (5) was found not to be a violation of NYC Health + Hospitals HIPAA Privacy Operating Procedures; and six (6) are still under investigation.

- All seven (7) incidents confirmed as violations were determined to be breaches. A total of 1,634 individuals were affected by the seven confirmed breaches.

### Breach Defined

3) 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.<sup>8</sup>

4) 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.<sup>9</sup>

### Factors Considered when Determining Whether a Breach has Occurred

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<sup>8</sup> 45 CFR § 164.402 [“Breach” defined].

<sup>9</sup> See 45 CFR § 164.402[2]; see also 78 Fed. Register 5565 at 5643 and 5695 [January 25, 2013]

5) 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:<sup>10</sup>

- 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.

#### Reportable Breaches in the 3rd Quarter of 2015

6) As stated above, there were seven reportable breaches in the 3rd Quarter. Below is a summary of these breaches:

- Lincoln Medical and Mental Health Center (“Lincoln”) – July 2015. This breach occurred when a patient improperly received the follow-up appointment reminder intended for another patient. The second patient refused to return the appointment reminder upon request from the Lincoln staff and therefore the incident was determined to be a breach. Breach notification was sent to the patient on September 14, 2015.
- Lincoln – July 2015. This incident took place with a patient improperly received appointment information belonging to another patient. The incident was only discovered when the patient who improperly received the information returned to the facility for follow-up care on the date when the other patient should have appeared. The documents were retrieved by the facility and proper notice to all parties provided. Breach notification was sent to the affected patient on September 14, 2015.
- Woodhull Medical and Mental Health Center (“Woodhull”) – July 2015. This incident occurred when a patient received the referral documents of another patient. Upon noticing the mistake, the patient returned the documents

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<sup>10</sup> See 45 CFR § 164.402 [2][i-iv].

belonging to the other patient, but having read the information the incident was determined to be a breach. The breach notification was sent to the affected patient on September 9, 2015.

- Woodhull– August 2015. This breach occurred when a laptop that was connected to an electromyogram (“EMG”) machine was stolen from a patient examination room within the hospital. The laptop had been physically secured with a cable that was cut during the theft and was further secured by means of a password required to gain access. Although the laptop was password-protected, it was not encrypted because of its age and contained the PHI of approximately 1,581 patients. The PHI contained on the laptop included patient names and test results but did not include social security numbers or financial insurance information. Breach notifications were sent to the affected patients on October 19, 2015.
- Lincoln – August 2015. This incident consisted of the disclosure of protected health information for 48 patients who were treated for Legionnaire’s disease at the Lincoln Medical and Mental Health Center. The disclosure was made by a Lincoln infectious-disease department physician who improperly used PHI to conduct an unauthorized research project in which the physician transmitted the PHI of Legionnaire’s patients, without their authorization or consent, to a private laboratory in Pennsylvania for further analysis. The physician was suspended from his duties at Lincoln and subsequently resigned. Breach notification was sent to the affected patients on October 23, 2015.
- Kings County Hospital Center – September 2015. This incident involved the disclosure of patient information by an employee to the family member of a patient. During investigation by the OCC and the Facility Privacy Officer, the employee admitted to disclosing the patient information. The employee resigned prior to receiving disciplinary action. Breach notification scheduled to the affected patient on Dec 1, 2015.
- Woodhull Medical Center – September 2015. This incident involved a patient receiving discharge documents affixed with a label containing PHI belonging to another patient. The patient reported the incident to Patient Relations and returned the documents. Breach notification sent on November 24, 2015.

Office of Civil Rights (“OCR”) inquiries regarding past Privacy Incidents

7) In the third quarter, there was one inquiry from OCR Below is a summary of said inquiry:

- Metropolitan Hospital Center – September 2015. OCR inquired about a breach reported by Health + Hospitals in June 2015 involving an unauthorized email containing PHI sent by an employee to his personal email account. The incident was captured by Health + Hospitals Data Loss Prevention Program (“DLP”) and investigation revealed that the employee sent the information to his personal email account so he could do HHC work while employed at another job. The employee was terminated and breach notification was sent to the affected individuals on June 1, 2015. The matter is presently under investigation by the Inspector General and OCC’s response to OCR was submitted on October 16, 2015.

8) In the fourth quarter, two additional inquiries from OCR were received on November 16, 2015. Below are summaries of both inquiries:

- Bellevue Hospital Center – November 2015. OCR is inquiring about a breach reported by Health + Hospitals in April 2015 involving an unauthorized, unencrypted email sent by a NYC Health + Hospitals/Bellevue employee. The employee sent the email with a spreadsheet containing information of 3,700 patients to her brother’s work e-mail account for the apparent purpose of obtaining assistance with her work.

The incident was captured by Health + Hospitals DLP Program. The investigation concluded that the employee sent the email to request assistance with Microsoft Excel program for completing a work related task. All information was deleted from known sites and affidavits attesting to the deletion of the PHI were obtained from those parties who improperly received the information. The employee was suspended for two-weeks for the violation. Breach notification was sent to the affected individuals on April 28, 2015. The OCC received OCR’s inquiry on November 16, 2015, and is currently preparing a response.

- Jacobi Medical Center – November 2015. OCR is inquiring about a breach reported by Health + Hospitals in April 2015 involving multiple unauthorized, unencrypted emails sent by a former NYC Health + Hospitals/Jacobi employee. This breach occurred when the former workforce member emailed documents containing PHI to her personal email account days after

she had resigned from NYC Health + Hospitals. Some emails were also sent by the former employee to the email account of the individual's new place of employment.

The incident was captured by Health + Hospitals DLP Program. The investigation concluded that the former employee had improperly retained access to her HHC email account even after ending her employment with Jacobi. An employee responsible for ensuring that the employee's access was terminated did not do so in a timely fashion resulting in the breach and that employee resigned her position with H + H.

As a mitigation measure, access to the former employee's email account was immediately terminated. Breach notifications were sent to the affected individuals on April 28, 2015, and included the offer of credit monitoring services. Because the breach involved the former employee accessing NYC Health + Hospitals email system after termination of employment, the case was also referred to the Office of Inspector General ("OIG") for further investigation. The OCC received OCR's inquiry on November 16, 2015, and is currently preparing a response.

## **VII. Compliance Reports for the Third Quarter of CY 2015**

1) For the third quarter CY2015 (July 1, to September 30, 2015) there were 74 confidential compliance-based reports (making a total of 268 for CY2015 as of September 30) of which none were classified as a Priority "A", 18 (or 24.3%) were classified as Priority "B", and 56 (or 75.7%) were classified as Priority "C" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints. Of the 74 reports received during this period, 48 (or 64.9%) were compliance complaints received on the OCC's anonymous toll-free compliance hotline.

### Mode of Reporting

2) Below is a summary of how the OCC received the 108 CY2015 second quarter reports:

- a. 48 (64.9%) were received on the Help Line;
- b. 9 (12.2%) were received via Telephone;
- c. 7 (9.5%) were received via E-mail;
- d. 4 (5.4%) were received via Face-to-Face;
- e. 1 (1.4%) were received via Electronic Fraud and Abuse Form;
- f. 1 (1.4%) was received via Interoffice Mail;

- g. 1 (1.4%) was received via Mail;
- h. 1 (1.4%) was received via Office Visit;
- i. 1 (1.4%) was received via Other means;
- j. 1 (1.4%) was received via Referral from another HHC Office.

### Allegation Class Analysis

- 3) The breakdown of the allegation classes of the 108 reports received in the second quarter of CY 2015 is as follows:
- a. 20 (27%) Employee Relations;
  - b. 14 (18.9%) Other;
  - c. 14 (18.9%) Policy and Process Integrity;
  - d. 12 (16.2%) Misuse or Misappropriation of Assets or Information;
  - e. 6 (8.1%) Diversity, Equal Opportunity and Respect in the Workplace;
  - f. 5 (6.8%) Environmental, Health and Safety;
  - g. 3 (4.1%) Financial Concerns.

### **VIII. Update on DSRIP Compliance Activities**

- 1) The OCC has posted a new DSRIP compliance officer position and has commenced the recruitment process for an Executive Compliance Officer, who will be solely responsible for DSRIP-related compliance, privacy, and record management activities and initiatives.
- 2) The OCC is presently working on the expansion of the NYC Health + Hospitals OCC Compliance Helpline to accommodate DSRIP-related compliance complaints, queries, and other reports.

### **IX. Compliance with the Public Authorities Accountability Act of 2005 and Reform Act of 2009 (“PAAA”) – Status Update**

- 1) The OCC continues to work with the Office of Legal Affairs (“OLA”) to assess NYC Health + Hospitals’ (as well as all wholly owned subsidiaries) compliance with PAAA requirements.

**X. FY16 Corporate Compliance Work Plan – Status Update**

1) The OCC has developed a draft confidential FY16 Corporate Compliance Work Plan, which will be submitted to OLA's outside counsel Katten Muchin & Rosenman, LLP ("Katten") for review early next week. Once reviewed as to acceptability as to legal form by Katten, the Work Plan will be finalized and submitted for approval to NYC Health + Hospitals President and Chief Executive Officer Ramanathan Raju, MD, in December 2015. The final Work Plan will be disseminated to the Audit Committee thereafter.