NYC HEALTH+ HOSPITALS

AUDIT COMMITTEE	**January 11, 2018**
MEETING AGENDA	
	10:30 A.M.
	125 Worth Street,
	Rm. 532
	5th Floor Board Room

CALL TO ORDER

- **Adoption of Minutes December 7, 2017**   **Ms. Emily A. Youssouf**

ACTION ITEMS

- **KPMG June 30, 2017 Management Letter**   **Ms. Maria Tiso**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

<table>
<tr><td>**AUDIT COMMITTEE**</td><td>**MEETING DATE: December 7, 2017**
TIME: 11:00 AM</td></tr>
</table>

COMMITTEE MEMBERS
Emily Youssouf, Committee Chair
Stanley Brezenoff
Josephine Bolus, RN
Mark Page

STAFF ATTENDEES
Salvatore J. Russo, General Counsel, Legal Affairs
Colicia Hercules, Chief of Staff, Chairman's Office
Patricia Lockhart, Secretary to the Corporation, Chairman's Office
PV Anantharam, Senior Vice President/Corporate Chief Financial Officer
Jay Weinman, Corporate Comptroller
Wayne A. McNulty, Corporate Compliance Officer/Senior Assistant Vice President
Christopher A. Telano, Chief Internal Auditor/Senior Assistant Vice President
Kim Mendez, Chief Nursing Executive
Chelsey-Lyn Rudder, Deputy Press Secretary
Carlotta Duran, Assistant Director, Office of Internal Audits
Frank Zanghi, Audit Manager, Office of Internal Audits
Sonja Aborisade, Audit Manager, Office of Internal Audits
Armel Sejour, Senior Auditor, Office of Internal Audits
Jean Saint-Preux, Staff Auditor II, Office of Internal Audits
Robert Hogan, Staff Auditor II, Office of Internal Audits
Jessica Fortes, Staff Auditor, Office of Internal Audits
Roshney Kaur, Staff Auditor, Office of Internal Audits
Pantelis Papadopoulos, Staff Auditor, Office of Internal Audits
Angelo Mascia, CEO, Sea View Hospital Rehabilitation Center & Home
Nancy Endozo, Director, Sea View Hospital Rehabilitation Center & Home
Ernest Purefied, Senior Associate Director, Harlem Hospital

A meeting of the Audit Committee was held on Tuesday, December 7, 2017. The meeting was called to order at 11:03 A.M. by Ms. Emily Youssouf, Audit Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee held on October 25, 2017, the motion was seconded.

Ms. Youssouf then turned the meeting over to Mr. Chris Telano of Internal Audits.

Mr. Telano saluted everyone and stated that he will start his briefing in which he will go over the external audits currently being conducted by the City and the State Comptroller's Office. The City's Comptroller's Office review of EPIC, started over a year ago, and the fieldwork ended in September, and we have not heard from them since, which is good news.

Moving on to the nurses' qualifications audit done by the State Comptroller's Office. The audit is completed, we had an exit conference on October 31st. A summary of the findings is (1) the lack of background information, and fingerprinting for nurses hired through temporary agencies; (2) missing employment documents; and (3) inconsistencies in the titles and salaries of the nurses employed by At Home Healthcare. We are expecting a draft report next in which we will have 30 days to provide them with a response.

Ms. Youssouf asked if these concerns were at At Home or throughout the system. Mr. Telano answered that findings one and two were throughout the system.

Mr. Telano continued on with the completed audits. The first one on page five is the follow-up audit of Transaction Control Errors (TCE). This is the first follow-up audit to be presented to the Committee in the seven and a half years since I have been here. During the course of our follow-up audit, we came across a new finding in which prisoner patient account claims were unbilled, and as you can see by numbering in the middle of the page, the long process that's involved in processing these bills. Primarily the accounts have to be converted from a Medicaid Health Maintenance Organization (HMO), to a Medicaid Fee-for-Service (FFS). Revenue Management forwards the account listing to Human Resources Administration, and then they return the list, and we are finding that many of the accounts are not properly converted, and what has happened that has resulted in the unbilling is that the list was returned to Revenue Management, but they were not acting upon it nor contacting HRA to resolve this issue.

As a result of the audit, meetings are being held with HRA to streamline the process and internal processes have been implemented to ensure that there is a second review of the accounts that were not converted properly.

Mr. Page asked does it make sense that it's going to HRA and this group in the middle? To which Mr. Telano responded that I believe it has to go to HRA to be converted.

Mr. Anantharam added that it used to be when HRA did all of the designations, it was a lot easier because it was local. Now the State has taken over a significant number of the ancillary functions, decentralizing across the whole state, so the process now is that we send it to HRA, and HRA then has to send it to the Department of Health, State Department of Health and then it is authorized and approved and sent back to us for billing and Fee-for-Service. We are trying to streamline that process a bit and use HRA. We also have weekly calls with the State, which for some time have been stopped, but it is back on the table, so this Friday we will have another conversation with the State in terms of ongoing business that we have on DSH UPL and certain items. To some extent that has been resolved. We are thinking that, and I intend to bring it up with the State to see if there are other means of doing this in a speedy fashion.

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Mr. Telano continued, information from two different systems, 3M and UNITY, are downloaded into the Patient Billing System. If that information doesn't match in the system, they kick out to a TCE.

In the follow-up audit, there were eight initial findings, and five ended up being unresolved, two were partially resolved, and one was fully resolved as you can see outlined on the table.
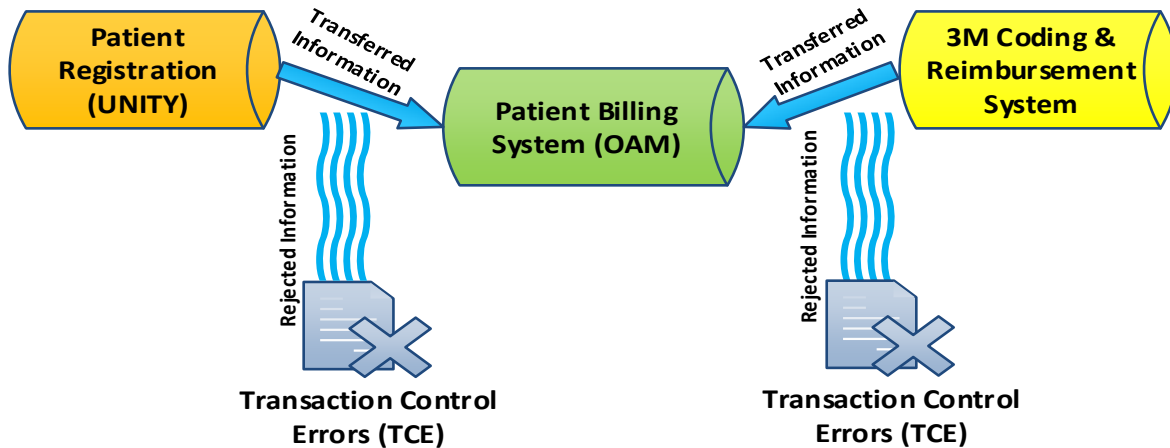
They had found that basically only six codes or six of those items in the 150-page report are relevant and have financial implications. Meanwhile we have been reviewing this report for many years in-depth. Much resources have been applied to reviewing this report, and it's not user-friendly, so in order to find these three codes, you almost have to go to the 150 pages. It's not in Excel format or anything.

Ms. Youssouf asked if there were 150 pages?

Mr. Anantharam answered that the lack of synchronization between events that happened at the front end and the billing sections create a lot of errors. Many of them are appropriate to be corrected. They just don't have revenue implications. We have been under and these are UNITY systems, so they date back a while. The expectation had been to implement SORIAN across the System that it could actually resolve them. Subsequently, we decided that was not a better option and that we were going to go for a holistic issue in EPIC, so those transaction errors continue to be there, and as we looked through them, there could have been means of addressing them through software modifications, but that would have cost more money than anticipated so what we have done now is engaged the team in webinars to tell them what they should and should not look for and also try and segregate the TCEs so that they focus their efforts only on those that are included.

Ms. Youssouf asked what team? To which Anantharam answered the patient accounts teams at the hospitals who actually correct these errors.

Ms. Youssouf then asked ask as EPIC gets rolled out, is that going to eliminate this?

Mr. Anantharam responded yes, it may raise other issues.

Mr. Telano said that the other unresolved issues will be addressed by the Chief Financial Officer of Bellevue, so they will be resolved eventually if not already.

Mr. Telano moved on to the next audit One-to-One Nursing Supervision at Sea View. He asked for the representatives to approach the table and introduced themselves. They did as follows: Angelo Mascia, CEO; Nancy Endozo, Director of Nursing.

Mr. Telano said that I'll go through the findings, and you can address them.

Finding A, many recordkeeping errors occurred primarily because it's a fully manual system regarding the medical records, and we had difficulty going through because of missing documentation or it was misfiled in another resident's chart.

Finding B, we found that residents were on one-to-one observation for an extensive period of time from 254 to 261 days.

We also found recordkeeping errors in regard to the one-to-one process. There are five examples of non-adherence to physician orders. After the first bullet point, you see a dash, for example the physician had discontinued the physician's order on August 1st, and if you look at the paperwork that is completed when someone is still on one-to-one, it appears that that resident stayed on one-to-one for the entire month of August.

Going on to the next one, a physician ordered one-to-one on June 9th. It didn't begin until June 10th.

There are other examples; it was January 2nd for the order but it was not implemented till the 3rd, and another one ordered on September 2nd but not implemented till September 3rd. The last dash is that a physician ordered one week of monitoring on July 14th. However, there's no indication that there was any one-to-one until July 30th, and we looked at documents, and we could not find anything to support that.

The last one has to do with the behavior observation logs that were missing from medical charts of various residents.

Mr. Page asked could you just tell me, I guess it should be self-evident, but what exactly does one-to-one observation mean. Literally is that a 24-hour shift operation with literally one nurse watching one patient? What does it mean?

Mr. Mascia answered that it's a nurse's aide. A primary care technician they call it in the System where you have to watch the patient, not one nurse, but over 24 hours three shifts watch, naturally when they are sleeping, as opposed to let's say you have to carry six patients. Under one-to-one supervision, you are always with this one patient.

Mr. Page asked if that's only done by order of the doctor and it can only be taken off by order of the doctor. There's no nursing judgment involved when this would be more important or less important.

Mr. Mascia responded that they work together on it. They discuss the behavior change, let's modify. We do that. As of the time of the audit, we had started a project, a quality-improvement project with the Post-Acute Care Service Line where basically we got rid of one-on-ones, so we just didn't have any more one-on-ones.

Ms. Youssouf asked that does that mean you don't do one-to-ones anymore.

Mr. Mascia answered, right.

Mr. Youssouf asked, at all?

Mr. Mascia responded that we have close supervision and different types but not the exact one-to-one where overtime was spent. You had to do it if you were short staffed. It's better communicating between the nurses and the nurses'

aides and all the action with the doctor. We haven't gotten some of the patients that we had a year ago. There were some patients that were just uncontrollable.

Mr. Youssouf asked if a physician does not have the ability to order a one-to-one anymore.

Mr. Mascia answered, if they feel it is necessary.

Ms. Youssouf asked, could you explain how you got rid of them.

Mr. Mascia responded that the physician can order them if they are needed. It's just that I guess the criteria for ordering the one-on-one has changed. We do more behavior logs. We check it over a 24-hour period that the patient is having these behavior problems, and that helps determines whether or not you have to put one-to-one.

Ms. Endozo added that there is closer observation where the staff is being rotated every 30 minutes to watch the resident for example residents with behavior issues, but before we were doing a one-to-one, like one nurse's aide is assigned to one resident as opposed to a closer observation where you put a cohort. Residents with behavior, maybe one nurse's aide can watch two residents, but what we are doing is doing a staff rotation, and it's not even progressed to a one-to-one.

Ms. Youssouf stated that I'm confused now because you said you weren't doing anything. Now you are doing them, they could be ordered, but you just said they rotate every 30 minutes.

Ms. Endozo said that if it's necessary, but if the one-to-one is for a resident who has behavior issues, danger to themselves or danger to others, the one-to-one is really necessary. We haven't had that kind of resident.

Mrs. Bolus asked if that's the reason why has it been decreased. We don't have that kind of patient?

Mr. Mascia responded that a majority of the reason would be also -- I told you we have a quality-improvement measure with the Service Line where we did behavior logs to track to see if patients do really need a 24-hour one-to-one supervision. Is it that they are only active when the sun is down, or is it their behaviors are bad when it's early in the morning or after dinner? By tracking the time of their behavior problems, we are able to –

Mr. Brezenoff added that the essential point is this starts with the assessment of the patient. What the patient needs in order to protect, safeguard and meet the needs of the patient. They have a variety of techniques. Those techniques when applied to the patient mixes that currently exist have not required actual one-to-one, but a range of these kinds of services. It is possible though that a doctor might see a particular patient in a certain way, or a patient might come in who doesn't fit what the pattern has been, and a one-to-one could be ordered. It's like a doctor's prescription.

Ms. Youssouf stated that I understand that, I'm sorry. I just did not feel like you guys were explaining very well what was going on, so thank you for the explanation. Kim would you like to add anything?

Dr. Kim Mendez commented that we are looking at this across our System. If we look at this and break it down, we basically have two categories. One category is patients that would require really a one-to-one, a suicidal patient, and one who is a harm to himself or others. Then there's an opportunity to have a patient who needs close observation, meaning you don't have to have someone setting next to them side by side.

A physician actually needs to order a one-to-one, and that is available at all of our facilities if the patient needs that level of oversight. A nurse can actually do a close observation and order -- you don't even need an order. You can actually put that into place based on the need of the patient. You do not need a physician order for that.

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As Mr. Brezenoff said, it's based on assessing the patient, and it can change throughout the day. A patient may be more active and need more oversight during the day, and at night they don't need that, so that's a nursing judgment and a nursing activity that happens. As you were saying, it may be if we put someone on close observation that a nurse aide will actually observe that patient every 30 minutes, it could be every hour during the day, to make sure that there are no concerns or issues that need to be escalated in any way, so there's flexibility in that, and the reason for addressing it like this is to utilize our staff really in the most efficient way based on what the need of the patient is throughout the day and throughout their stay, and that can change from day-to-day and throughout the day.

Ms. Youssouf asked if that will address the issues that were found in this internal audit report?

Dr. Mendez responded that I think it addresses workflow and ordering issues. I think some of the other areas are that you are all on paper, so we need to actually ensure that we have a review and an audit of documentation based on the type of observation or one-to-one that the patient is on. Each one of those levels of caring for the patient require documentation.

Ms. Youssouf stated that that helps very much.

Mrs. Bolus asked when are you scheduled to come off paper?

Mr. Mascia answered that presently the Service Line is looking not to be part of EPIC. There may be an RFP about to go out on the street or may be on the street for long-term care only because EPIC didn't have a long-term care product, so it's coming. We don't have exact dates yet.

Ms. Youssouf asked are you opting not to be part of EPIC. Is that what I heard?

Mr. Mascia said that t's not that we are opting. They don't have a long-term care module. We would have to develop it with them and pay them to develop it.

Mr. Brezenoff said that it's an open question as to EPIC is in development for long-term care, but on the planning here, long-term care was way at the end of the queue, so there is an imperative to do something about the reliance on paper, and we are looking at alternatives, but we are also looking at the Epic development, and once it's developed, it has to be tested against our needs. This is a question that will probably come to the Board once we've figured out what the best way to go is in the coming year.

Ms. Youssouf stated that since we are having somebody new come in as the head of IT, hopefully that will be very helpful because they may have done something like this previously.

Mr. Telano stated that that concludes his presentation.

Mr. Page commented that maybe this is repeating what was already said, but what I'm understanding is that the care needs of the patient are a more nuanced question in terms of how best to cover the need with the way the nursing staff works. And this one-on-one as a yes/no, it has to be prescribed by a doctor, it has to come off, part of the problem here is probably that that doesn't have the flexibility in it to reflect the reality of the judgment of the people taking care of the patient from hour to hour as you go through the day. And I understand that the documentation is a problem. If you had this system, it needs to be worked right. That's kind of what we are talking about, but more broadly, it sounds as though you are saying you have actually moved into something that better enables you to adjust to the ongoing need of the patient than this on/off switch of one-on-one could easily accommodate.

Dr. Mendez stated that looking at the close observation or one-to-one does allow a great deal of flexibility. With the one-to-one in the physician order, it does require every 24 hours that you have a review of the patient and you have to reorder that. It's not an automatic for a one-to-one.

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

Mr. McNulty introduced himself as Wayne McNulty, Chief Corporate Compliance Officer and Senior Assistant Vice President ("CCO") and reported that I'm going to start with the overview of Operating Procedure 50-1, Corporate Compliance and Ethics Program, and discuss the revisions to that Operating Procedure.

I'm going to start with the overview of Operating Procedure 50-1, Corporate Compliance and Ethics Program, and discuss the revision to that Operating Procedure. It is the policy of the System to make sure that we have an effective Corporate Compliance and Ethics Program and that we are viewed in the community as the status of an honest, reliable and trustworthy healthcare provider.

Some of the other key initiatives is to eliminate fraud, waste and abuse, to mitigate system-wide risk and to promote ethical conduct and good governance. To meet these policies goals back in 2009, the System established Operating Procedure 50-1, which is the Corporate Compliance Program. That operating procedure was amended in 2010 to further clarify the System's Disciplinary and Retaliation Policy.

Since 2010, the Operating Procedure has not been amended or supplemented. We are now revising that Operating Procedure to meet current regulatory standards and implement guidelines and to expand the scope and build the Operating Procedure to make sure that it's clarified that it covers all workforce members, business partners and agents of the System.

I just want to briefly talk about the legal requirements. Under state law, Health + Hospitals is required to establish and maintain an effective compliance program, and when establishing that program there's certain elements that we must meet. One of those elements is to establish written policies and procedures that describe the compliance expectations that implement the operation of the compliance program and identify how workforce members, business partners and agents could communicate compliance issues to the Chief Compliance Officer.

Similarly, the Federal Office of the Inspector General of the United States Department of Health and Human Services, they issued guidelines, and one of their guidelines, which we adopt the principles thereof, call for the written implementation of written policies and procedures in the establishment of a corporate compliance and ethics program.

The United States Sentencing Commission Guidelines Manual, which we adopt the principles thereof, also calls for the implementation of written policies and procedures and the adoption of a corporate compliance and ethics program.

The revised 50-1 outlines the following:
- ✓ The definition of key terms, compliance, ethics, fraud, waste and abuse and retaliation.
- ✓ We, as I stated, clarify the scope of the program to cover all workforce members, business partners and agents.
- ✓ We provide a more detailed disciplinary policy to outline the sanctions for those who fail to affirmatively participate in the program.
- ✓ We also provided more detail as to our whistleblower protection policy under Labor Law 740 and 741, and we included numerous attachments to the Operating Procedure, which assists workforce members, business partners and agents to better understand their compliance obligations, to ensure that certain documents referenced in the Operating Procedure are easily available for their review and to further inform and educate these individuals on the fine nuances in their various program requirements.

We have a summary of the key points and key responsibilities that workforce members, business partners and agents must comply with to affirmatively participate in the program, and collectively I'm going to refer to those three groups of individuals as covered persons. Covered persons who fail to affirmatively participate in the program will be subject to disciplinary action up to and including termination of the employment, contract or other relationship with the System.

The first area is that all covered persons must adhere to compliance standards. The System has established an organizational culture of compliance, a focus on the prevention and detection and resolution of any compliance conflict, and all covered persons must refrain from engaging in any activities that would violate System internal policies and procedures or federal or state law.

We are committed to ethical conduct, and ethical conduct in a nutshell is to do the right thing, and we expect all covered persons to act fairly and honestly in carrying out their System functions, duties and responsibilities. We are committed to protecting the privacy and security of confidential information, and such confidential information includes not only patient information, but confidential employee information and confidential business information.

We are committed to ensuring that our covered persons adhere to different standards of conduct. There are several standards of conduct that the System has either adopted or promulgated. I'm going to go through three key standards of conduct. The Principles of Professional Conduct, which outlines the compliance expectation that all covered persons must follow, that was adopted by the Board of Directors last April in 2016.

Chapter 68 of the New York City Charter, which applies to all System employees and members of the Board of Directors, which outlines different conflicts-of-interests provisions that System employees and members of the Board of Directors must follow. And a Code of Ethics, which was promulgated by the System and binds all System affiliate personnel as well as members of the Auxiliaries and member of the Community Advisory Boards and other subcontractor personnel that perform functions and duties at Health + Hospitals that are not covered by Chapter 68.

We require all covered persons to report compliance issues, and if you see something, say something. We have a Compliance Help Line, which they can call anonymously, and all reports are maintained confidentially. We have a separate Compliance Health Line for DSRIP-related issues that not only individuals that are in Health + Hospitals that are involved with DSRIP may call, but all the DSRIP partners can call and access that line also. We strictly prohibit retaliation of anyone that reports a compliance issue in good faith, and anyone that retaliates against an individual would be subject to disciplinary action. Then we outlined in this one-page back-and-front summary the prohibited activities. Any of the activities that I mentioned above are strictly prohibited.

We mandate that everyone participate not only in the Corporate Compliance Program as outlined in OP 50-1, but related compliance policies and procedures, discipline with respect to anyone who fails to report a matter to government officials or regulatory bodies when required by law to do so, and anyone failing to comply with federal healthcare program requirements, either Medicare, Medicaid or Tricare.

As I stated before, any violation of OP 50-1 or these seven mandates will result in disciplinary action up to and including termination of employment, contract or relationship with the System. Are there any questions with regard to OP 50-1?

Ms. Youssouf commented that the OP 50-1 is over 200 pages and will be available on the website for anyone who would like to look at it in detail probably next Friday.

Mr. McNulty added that by next Friday it will be presented to the President for a signature and then will be uploaded completely onto the website thereafter.

Mr. McNulty then moved on to the Corporate Compliance report. November 5th through November 11th was Corporate Compliance and Ethics Week. This year's theme was to make good choices, and Health + Hospitals continues to make good choices by maintaining an effective corporate compliance ethics program, focus on the terms fraud, waste and abuse.

Monitoring of Excluded Providers, as you are aware, we review on a monthly basis the status with respect to all workforce members and vendors whether or not they are on three separate sanction lists, a sanction list by the Office of Inspector General, one by OMIG and one by General Services Administration. We also look to see if workforce members or vendors are on the Office of Foreign Asset Control Screening and if they are on the Social Security Death Master's list.

We had one workforce member that we identified September 19, 2017, as being on the OMIG exclusion list. This individual worked, referred patients to Home Care, but we didn't have any patients referred by this individual since the individual was excluded. If any patient is referred by this individual, we will make sure that a physician in Home Care issues an appropriate order to make sure that the order is appropriate, and we can bill thereafter.

Privacy Incidents and Related Reports, we are going to first talk about the second quarter of 2017, April 1 to June 30, 2017. In that particular time frame we received 24 complaints, privacy complaints. We determined that 14 were violations of our policies and procedures, seven were unsubstantiated, three were not violations, and three were determined to be breaches of protected health information.

Reportable Incidents from July 1, 2017, to September 30, 2017, the third quarter, we had 21 reports received. Eight were considered to be violations of our HIPAA policies and procedures, and three were considered to be breaches of protected health information.

The breaches are as follows:
- ✓ One incident occurred at Harlem Hospital where two employees accessed the records of their supervisor, who was a patient, so obviously it was a breach of protected health information. It was not an authorized access. The employees were immediately suspended, and a formal labor management hearing is going on with respect to those two individuals.
- ✓ Second incident, we had an employee who inappropriately accessed the records of a patient on multiple occasions. This employee had authorization to receive certain information related to the patient and was focused in on somewhat in a role of personal representative of the patient, but that did not give the employee the ability to utilize their job access to access the full record, so it went beyond the scope of what the patient authorized number one, and number two, the employee violated our procedures by gaining access in a course that's not sanctioned by the System. So there was a breach of information, we provided notice to the patient, and a formal labor management hearing had occurred, and disciplinary action is to be taken.

Mr. Page asked how you found that out.

Mr. McNulty answered that we reviewed the records, can look at the access log of any employee and found out this employee went into the record and it was unauthorized.

- ✓ Third incident, at Harlem Hospital, we had a physician who discussed the medications that a patient was receiving in the presence of a visitor without the patient's authorization, and that resulted in a breach of health information. That physician was later retrained with respect to HIPAA policies and procedures, and my office is actually following up on the disciplinary action that took place in that particular incident.

Turning to Reportable Incident from July 1, 2017, to September 30, 2017, the third quarter, we had 21 reports received. Eight were considered to be violations of our HIPAA policies and procedures, and three were considered to be breaches of protected health information. The first breach occurred when an employee inadvertently uploaded the information of 17 patients to his or her Facebook page. They inadvertently took a picture of a unit while they were in a unit, and the information happened to be laying on a log.

Ms. Youssouf asked and you can read it?

Mr. McNulty answered yes, and it was uploaded to the person's Facebook page. We determined after investigation that it was inadvertent. Some individuals have their social media pages automatically set that when they take a picture it is automatically uploaded to the social media page, so we think that's what happened in this particular incident here.

Mr. McNulty continued on to the incident, a nurse at Jacobi Medical Center disclosed protected health information to the visitor of a patient assuming that the visitor was aware of the patient's medical condition, and again that was a breach of protected health information, and the nurse had been subsequently counseled and completed a comprehensive in-person HIPAA training course. Lastly, at Metropolitan Hospital Center, there was an EEG technician that performed tests on three patients. The problem was that he EEG technician did not go through the normal Human Resource process with respect to being processed as a workforce member, and therefore it was considered a breach of protected health information.

Ms. Youssouf asked how long has that person been employed?

Mr. McNulty responded that it was just these three patients that the workforce member saw, and it was just on that one night. That physician had asked the individual to come in and work with that EEG technician at another hospital the physician worked at and required a test immediately, and that is the route that the physician took, which was an improper route.

Mr. Brezenoff commented that it was a problem in staffing, and this was designed to solve the problem, which it did, but in an inappropriate way.

Ms. Youssouf asked what do you mean when you say the subject director?

Mr. McNulty answered. The Chief Medical Director, Chief of Service. She brought in someone she works with at another facility and was aware the person was adequately trained. We were able to review the medical records of that individual and show that the medical records met our standards with respect to employee screening beforehand, and there was no incident with respect to any of the patients.

Mr. Page asked if this is an example of something that happens from time to time that we should actually be trying to accommodate officially in some way, or is that impossible and if it has to happen, then you are going to deal with it on an ad hoc basis it will be a violation of something?

Ms. Youssouf stated that it seems to me that the MPA Committee is the one to really delve into that because I don't think we all have the medical expertise to be able to figure that out, and Dr. Allen would have to figure out what is appropriate or not, so rather than have Wayne answer it, it's okay.

Mr. McNulty continued on to Section IV, Compliance Reports for the Third Quarter, from July 2017 to September 30, 2017. We received 86 reports. Three were priority A, which means they were serious reports. Thirty-five were Priority B and 48 were Priority C. At the end of the year we are going to go through all of the Priority A reports and will be presenting that at the executive session the next time the Audit Committee meets to discuss how those Priority A

reports were resolved and whether or not we implemented policies to ensure that reports of a similar nature are deterred, not that the reports are deterred but that activities and conduct alleged in the reports are deterred. From October 1, 2017, to November 29th, we don't have the full quarter, but I want to give you an update of the particular part of the fourth quarter, we received to date, to date meaning November 29, 2016, 64 compliance reports. Of those 64 reports, we have one Priority A report, 19 Priority B reports and 44 Priority C reports, and again we will summarize all of our Priority A reports for the year in executive session the next time the Audit Committee convenes.

Updating the information governance and HIPAA privacy policies and procedures. It is required by the New York State Department of Health regulations. Our policy and procedures should be reviewed on a biannual basis. There are certain accreditation standards that may require to be reviewed more frequently, and best practice is to review them at least on an annual basis, so to that end we looked at all the HIPAA policies and procedures. Several of those policies and procedures have since been updated, particularly in 2013 with the passage of the HIPAA Omnibus Regulations and rules in the HITECH Act.

There are three operating procedures that we believe are necessary that require revision. Those are operating procedures relating to our breach response and notification to patients and regulatory bodies, our minimum necessary operating procedure and our business associate agreement operating procedure. We have a minimum necessary operating procedure, but it's covered in several operating procedures, so we have provisions we are going to codify into one operating procedure. We are going to expand our breach response policies that are covered in one operating procedure and expand that significantly, not only to cover the breaches of protected health information, but any breach of employee private information, whether it be employee health information or employee confidential information such as Social Security numbers.

Interestingly enough, the state law that covers the breach of Social Security numbers only governs that breach if it's electronic. Our policy will cover not only if it's an electronic breach but if it's a paper breach. As a policy of the System, we don't see a difference. We want to notify our employees if there was a breach of paper information also. Those operating procedures, we to hit the President's desk for signature one week after Operating Procedure 50-1 hits the desk for signature.

The Systems of Principles of Professional Conduct we had previously put together a year ago, we reviewed it, and it's still in good shape and there's no need to further revise it. But we did put together frequently asked questions about the Principles of Professional Conduct, and that's included in Operating Procedure 50-1, and so those are the different areas that we are going to revise.

We are also going to create an operating procedure on overpayments, which we are actually going to be meeting on tomorrow, myself, PV, Sal. We have an operating procedure on fraud, waste and abuse.

We met our compliance with the Deficit Reduction Act of 2005. The Deficit Reduction Act mandates that the State Medicaid Office mandates that we inform our System workforce members, vendors, partners of all our internal policies and procedures designed to detect fraud, waste and abuse.

Ms. Youssouf asked overpayments, either us or them?

Mr. McNulty responded that when we receive any federal healthcare funds that we are not entitled to either because the claim wasn't appropriate or wasn't billed appropriately, we have to refund those moneys back to either the state government or the federal government, and so we are going to have an operating procedure to outline the procedure because there's a 60-day rule that once we determine that an overpayment has occurred that we have to refund it back.

Mr. McNulty continued and reported that with respect to page 22, we met our compliance with the Deficit Reduction Act of 2005. The Deficit Reduction Act mandates that the State Medicaid Office mandates that we inform our System workforce members, vendors, partners of all our internal policies and procedures designed to detect fraud, waste and abuse. We have to have a summary of those policies and procedures in any employee handbook that we have throughout the System, and we have to have certain training and educations with respect to fraud, waste and abuse. We sent out to all 40,000 workforce members and to all of our vendors a summary of the Deficit Reduction Act and all of the different laws designed to detect fraud, waste and abuse on a federal side and on the state side.

DSRIP Compliance Activities Update, we have previously reported that we had submitted an attestation to DSRIP partners so we could assess their compliance program integrity. As a PPS lead in the New York State DSRIP Program, we are responsible to make sure that our partners have a program integrity in place as it relates to compliance. The information that we received back was for the most part very, very positive. We received back from all 119 partners' verification that they have utilized our training education, that they adopted a code of conduct. We have one partner that said they didn't adopt a code of ethic, and we are following up with that one partner.

We have several partners who said that they did not screen their employees that are involved with the DSRIP Program for exclusions, so we are sending notice out to them that when the end of this month comes and they have to re-sign up to DSRIP through the Schedule B of the schedule, that's the schedule they re-sign, they will not be allowed to unless they verify to us they are doing exclusion checks. We also have several partners who stated that they were certified with OMIG as an effective compliance program, but they have not provided us proof of that certification. Again, if we don't receive proof of that certification, they will not be allowed to go on to the next year with respect to DSRIP.

Update on HHC ACO Compliance Activities, we have a meeting scheduled -- a meeting has been scheduled with respect to the ACO Board I believe will take place on the 18th of December. At that meeting we are going to present the ACO Code of Conduct. The ACO Code of Conduct is a mirror image of the Health + Hospitals Principles of Professional Conduct except there are additional provisions that are specific to the ACO Compliance Program and specific provisions specific to the Medicare Shared Savings Program regulations inside that particular Code of Conduct.

We will also be presenting a compliance plan to the ACO Board, and lastly we will be sending out to all the ACO partners before the end of this month compliance training education PowerPoint, which they could use or they could implement within their compliance training program or they could do a combination thereof.

Mr. McNulty said that that concludes my report.

Ms. Youssouf stated that as always for the last Audit Committee meeting, I just want to say both Chris Telano and Wayne McNulty do an outstanding job, and we are very grateful to you as H+H should be, and I'm sure they are. Thank you very much.

There being no further business, the meeting was adjourned at 11:53 A.M.

Submitted by,

Ms. Emily Youssouf
Audit Committee Chair

DRAFT

January 11, 2018

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 (NYC Health + Hospitals), a component unit of the City of New York, as of and for the year ended June 30, 2017, in accordance with auditing standards generally accepted in the United States of America, we considered NYC Health + Hospitals' 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 NYC Health + Hospitals' internal control. Accordingly, we do not express an opinion on the effectiveness of NYC Health + Hospitals' 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. During our audit, we noted certain matters involving deficiencies in 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 operational 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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Facilities	Financial Reporting	Patient Accounts Receivable	MetroPlus	Accounts Payable Subledger to General Ledger Reconciliation	Accounts Payable and Accrued Expenses	Grants	Liquidity	Information Technology	Tax Matters	Industry Issues
Corporate	X	X	X	X	X	X	X	X	X	X

Corporate Comments

Financial Reporting and Alignment of Finance Resources*

Observation

During the year-end audit of NYC Health + Hospitals, we noted inconsistencies in certain balance sheet classifications, footnote disclosures, management's discussion and analysis (MD&A) and required supplemental information.

Recommendation

As part of NYC Health + Hospitals financial reporting process, we recommend the following:

- Assess the organizational needs and the available finance staff resources to determine how to best structure the department.

- Perform a formal review of the complete financial statements, inclusive of the financial statements, footnote disclosures, MD&A, and required supplemental information at a level of precision to ensure they are fairly presented. This review should be performed by the Corporate Comptroller prior to submission to KPMG.

- We acknowledge that management utilizes a responsibilities checklist for the year-end close and audit; however, it should be updated to ensure it is up-to-date and covers all significant accounts and relevant disclosures. The updated checklist should ensure that there are reasonable deadlines to allow for the corporate finance department to review and record potential adjustments in a timely manner.

- As a leading practice, prepare a financial statement footnote disclosure checklist, to ensure that all required disclosures are included within the financial statements and in accordance with U.S. generally accepted accounting principles. In addition, management should consider preparing a footnote disclosure and MD&A binder with all relevant documentation provided in one place to support those disclosures.

Management Response

Management agrees that the use of a checklist for the year-end close will facilitate the completion of the financial statement. Management will also conduct appropriate training of staff to ensure accounting and financial reporting processes, including account analyses are performed to identify significant variances. A final review by the Corporate Comptroller will be completed prior to KPMG receiving the financial statements.

Patient Accounts Receivable

Observations

1. NYC Health + Hospitals has a process and methodology in place for evaluating the collectability of patient accounts receivable, including a review of the calculation by the Corporate Controller. The process includes an analysis of historical cash collections by payer based only on the Unity patient accounting system and does not include aging categories other than those greater than 365 days. Furthermore, the initial analysis prepared by management did not consider the actual historical collection experience of in-house balances, including large individual account balances, but rather used the collection experience of inpatient billed accounts. Additionally, there was a difference between the patient accounts receivable due to NYC Health + Hospitals from MetroPlus per management's calculation and the estimated MetroPlus liability due to NYC

Health + Hospitals. Management recorded an adjustment in the financial statements to patient accounts receivable as a result of properly valuing in-house accounts and the MetroPlus receivable that was not identified by management's initial calculation and methodology.

2. NYC Health + Hospitals currently has approximately $242 million of individual patient credit balances, which are included within the patient accounts receivable, net balance. These credit balances result from overpayments or mis-postings of contractual allowance adjustments. Although management has represented that the majority of the credit balances related to mis-postings of contractual allowance adjustments, a formal analysis has not been performed.

3. During the audit process, we identified significant charges on a single outpatient visit (over $150,000) that was a result of an incorrect quantity being entered into the patient account system. This error was not identified by patient accounting staff at NYC Health + Hospitals during the year and the inflated charges were included in management's analysis when evaluating the collectability of patient accounts receivables.

4. During the audit process we noted that unapplied cash or cash received by NYC Health + Hospitals but not yet applied to the patient accounting system was approximately $99 million at 2017.

Recommendations

We recommend the following:

1. Management should continue to refine its process and methodology in place for evaluating the collectability of patient accounts receivable, ensuring the review is performed at a sufficient precision level to identify any errors. Management's analysis should consider the potential impact of items such as aging, in-house accounts, individually significant balances, and the most recent collection experience from the Soarian patient accounting system. Management should continue to test its process by performing a historical hindsight analysis by comparing subsequent cash receipts to patient accounts receivable at year-end. Management should consider utilizing a data and analytics tools, such as the IDEA program, into its analysis, which would allow them to analyze large volumes of data. Management should also continue to reconcile the patient accounts receivable from MetroPlus to the estimated MetroPlus liability due to NYC Health + Hospitals. Any significant differences should be investigated.

2. Management should develop a process to review credit balances to determine the potential refund liability and potential impact on patient accounts receivable valuation. This process will be enhanced by management utilizing a data and analytics tool such as IDEA as noted above.

3. Management should develop a process to review significant account balances to determine if any of these balances are as a result of mis-postings and adjust these balances accordingly.

4. Unapplied cash balances should be monitored to ensure that the cash is applied to individual account balances on a timely basis.

Management Response

Management is planning on purchasing the IDEA software management tool, recommended by KPMG, to assist in the analysis for valuing the accounts receivable. Meetings are being set up with Cerner to develop the data requirements for use with IDEA so NYC Health + Hospitals can transition the valuation techniques to the new software.

The IDEA software will also facilitate a review of credit balances to ensure that they are properly reported in the financial statements as well as identifying accounts with significant balances to assess the appropriateness of such balances. Additionally, Management is refining its process for posting cash to minimize the unapplied cash balances.

Third Party Reimbursement Estimates

Observation

Management updates and adjusts its financial records based upon calculations and account analysis received by the reimbursement department related to third-party rate reviews and estimates. During our review of the third-party account analysis, we noted that there is no evidence of the formal review that takes place by the Comptroller's office. Additionally, the Controller's office did not obtain and review the source documentation for all significant assumptions.

Recommendation

Given the complexity of the third party reimbursement estimates, we recommended that management develop policies and procedures to ensure a sufficient detailed review of third party reimbursement estimates is performed by the Comptroller's office, which includes obtaining and reviewing the source documentation for all significant assumptions in order to ensure sufficient appropriate audit documentation exists.

Management Response

Management agrees with the recommendation and will review the calculations for third-party rate estimates to ensure all documentation is sufficient to support the assumptions used.

MetroPlus- Claims

Observation

MetroPlus Health Plan (MetroPlus) has contractual agreements with healthcare providers, which include agreed upon rates for which MetroPlus will pay the provider for services provided to its members. During the fiscal year-end audit, KPMG selected a sample of individual claims paid to test the accuracy of the claims paid amount to the underlying contractual agreement with the provider. The results of our test work identified differences between the rates in the claims processing system and the underlying contractual agreement for two outpatient providers (one lab company and one optometrist). These differences resulted in overpayments to the providers by MetroPlus. Upon further review by MetroPlus management, it was determined that the accumulated overpayments approximated $40 million, of which approximately $7 million related to the current fiscal year. Management's claims review process failed to identify these overpayments.

Recommendation

We recommend that management enhance its existing policies and procedures in place over claims processing, including contractual rates entered into the claims processing system. For example, management should ensure that all claims are subject to testing, including those that are auto-adjudicated by the system. In addition, Management should evaluate whether its threshold for sampling of all high dollar claims is at a sufficient level for outpatient claims. Management should also ensure its procedures including testing of claims to rates in the contractual agreements.

Management Response

MetroPlus agrees that the two contracts were initially set up to pay the incorrect fee schedule. The fee schedules utilized were the standard for the Plan and at a view would look to be correct, with that the Plan has designed and started implementing enhanced claim payment testing. In addition to the 2016 and 2017 testing enhancements, as well as, the immediate review of all Lab and Vision contracts; MetroPlus has implemented a review of vendor contracts with payments over $1 million, to date 50% have been reviewed with no errors found. MetroPlus has also enhanced existing testing of manual and auto-adjudicated claims by adding reviews that tie to the contract rate. The MetroPlus Provider Maintenance Unit will now select Bi-monthly samples of standard and non-standard provider contracts for review of fee schedule setup. All of these additional efforts will aid the Plan in its quality review process of not only new and amended contracts but of existing contracts in our system. We will work to improve our claims payment process as well as the contract load process to improve outcomes.

MetroPlus- Management Review of Account Analysis

Observations

During the audit, we identified two instances whereby the initial account analysis prepared by MetroPlus was either not updated for the most recent information (stop-loss receivable) or the analysis prepared identified the correction of a previously reported amount (pay-for-performance liability). Management's stop-loss receivable account analysis did not initially consider the most recent collection experience, inclusive of denial activity, which is an important factor used by management to calculate the receivable balance.

In addition, management did not initially include an accrual for amounts that have not been billed, but relate to the fiscal year end. Management subsequently adjusted the account analysis and recorded adjustments which resulted in a net reduction of $4.6 million to the stop-loss receivable. Management's review of the respective account analysis failed to identify these adjustments. In addition, management's pay for performance liability account analysis for the current year identified an over accrual of $5 million related to a prior year, which was adjusted in the current year. The adjustments recorded in the current year for the stop-loss receivable and pay-for-performance liability were not considered to be material to the financial statements of NYC Health +Hospitals.

Recommendation

We recommend that management enhance its policies and procedures to ensure timely review of the account analysis to support the balances recorded in the financial statements. This review should be performed by a qualified individual who is at least a level above the preparer and at a level of precision to identify any significant errors.

Management Response

1. Stop-loss receivable: MetroPlus will enhance the policies and procedures to review the most recent collection experience and denial activity in the preparation of the stop-loss receivable analysis. In addition, MetroPlus will compute and include an accrual for amounts not yet billed in the analysis. The analysis will be reviewed at a level above the preparer to identify and correct any significant errors on a timely basis.

2. Pay-for-performance liability: In accordance with MetroPlus' enhanced periodic review and communication process with NYC Health + Hospitals finance staff, MetroPlus will closely monitor the activity in this liability account and all other related accounts to ensure adjustments are recorded within the appropriate fiscal year.

Accounts Payable Subledger to General Ledger Reconciliation *

Observation

During the prior year and current year audit, KPMG noted that finance at the central office (Comptroller office) did not have a detailed accounts payable subledger report that reconciled to the general ledger.

Recommendation

We continue to recommend that management obtain a detailed accounts payable subledger 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.

Management Response

The current legacy-based system continues to present reporting challenges due to its lack of adequate management reports. Management believes that the accounts payable activity is properly reported in the General Ledger, but agrees that it cannot support the balances through a system report.

NYC Health + Hospitals has begun implementing a new Accounts Payable system (PeopleSoft Financials) during FY 2018, which is being phased in by facility throughout the fiscal year. When the system is fully implemented, Management will be able to support the accounts payable balance in PeopleSoft.

Accounts Payable and Accrued Expenses

Observation

During our search for unrecorded liabilities audit procedure, we identified one sample related to a capital acquisition that was not recorded as a liability, but rather recorded incorrectly as a capital contribution. Upon further review by management, management identified approximately $26 million of capital acquisitions that should have been recorded as a liability. Management adjusted the financial statements based upon their revised analysis to properly account for the $26M of capital acquisitions. Management's review process for the recording and classification of capital acquisitions failed to identify the proper recording and classification of capital acquisitions.

Recommendation

We recommend that management implements controls and update policies and procedures to ensure that purchased goods and services related to capital projects are properly accrued for as liabilities. Additionally, we suggest more frequent communication between the capital planning department and the accounts payable department.

Managements Response

Management agrees with the recommendation and CIP will be reviewed by the accounting department to approve all general ledger entries that have been recorded for accuracy and appropriateness. Additional training will also be conducted for the appropriate recording of CIP and other fixed assets.

Grants Receivable Reconciliation between General Ledger and Grants Sub-ledger

Observation

During the year-end audit we noted that management failed to appropriately reconcile their grants receivable detailed sub-ledger to the general ledger. As a result of our year-end audit procedures, which included reconciling the detailed sub-ledger to the general ledger and inquiring of management, an adjustment of approximately $40 million was recorded to reduce the grants receivable balance.

Recommendation

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

Managements Response

Management agrees with the recommendation and will perform detailed account analysis of grants receivable, along with quarterly meetings with the Grants department for reviewing all assumptions for completeness and appropriateness.

Liquidity *

Observation

NYC Health + Hospitals continues to face significant challenges pertaining to healthcare reform legislation, changes in federal and state healthcare reimbursement regulations, and continuous managed care market increases. Furthermore, NYC Health + Hospitals relies on funds it receives from Disproportionate Share Hospital (DSH) funding to supplement the services provided to a large share of Medicaid and low income patients. These DSH funds are to help cover the losses incurred from serving uninsured and Medicaid patients. DSH funds will be subject to federal cuts anticipated to take place in the near future. As a result of the changes in the current economic environment, substantial changes are anticipated in the U.S. healthcare system going forward, which will affect the delivery of healthcare services, the financing of healthcare costs, reimbursement of healthcare providers, and the legal obligations of health insurers, providers, and employers.

NYC Health + Hospitals has reported negative working capital in the most recent fiscal year and operating losses during the most recent two fiscal years, and during 2017 has received approximately $723 million from

the City of New York (the City) in appropriations. Going forward NYC Health + Hospitals will continue to face liquidity constraints and continued financial support will be required from the City as NYC Health + Hospitals continues to fulfill its mission of rendering healthcare services to a substantial number of uninsured patients.

Recommendation

Although, NYC Health + Hospitals has been aggressive in dealing with its financial challenges in a number of ways by creating the Office of Transformation charged with carrying out the goals of "Vision 2020" and Mayor Bill de Blasio's Transformation Plan, we recommend that management and the Board continue to keep their focus on such initiatives and take the necessary actions to ensure that NYC Health + Hospitals funding remains adequate in order to carry out its vital mission.

Management Response

Management will continue to support the efforts of "Vision 2020" and the "Mayoral Transformation Plan" towards financial stability and sustainability for providing ongoing healthcare to our communities.

Information Technology Comments

Password Configuration Settings*

Observation

During our testing, it was noted that the password configuration settings for Mainframe systems (GEAC and PSMS), OTPS, and the Windows network did not meet industry leading standards. Specifically, the settings for password minimum length, password expiration, password lockout, and password complexity as noted below:

- Minimum Password Length: A minimum password length of 6 characters does not match the industry standard of 8 characters for the Network and Mainframe applications.

- Password Lockout: For the Network, KPMG found that the configuration setting for password lockout was set to 10 attempts, which did not meet the industry standard of 5 failed login attempts.

- Password History: For Mainframe applications, KPMG found that the configuration setting for password history was set to 0 previous passwords remembered, which did not meet the industry standard of 3 previous passwords remembered. For the Network, KPMG found that the configuration setting for password history was set to 0 previous passwords remembered, which did not meet the industry standard of 3 previous passwords remembered.

- Password Complexity: For OTPS and the Network, KPMG found that complex (Alpha-Numeric) passwords were not required.

Recommendation

KPMG IRM recommends configuring the password settings to industry leading practices. Management should also update policy to specify password parameters.

Management Response

Minimum password length – Mainframe Minimum password length is 6 characters. This is currently minimum password length system limitation. The additional security protocols provided by Active Directory and Web-term logins, required prior to logging into Mainframe and OTPS helps effectively secured these systems.

Based on the recent changes made by Active Directory team, password complexity has now been implemented. Passwords must contain at least three of the following four character type, Uppercase, lowercase, numbers or symbols, and the password must be a minimum of 8 characters, which meets the industry standards. Password history is currently set to 5 (the five (5) most recent unique passwords utilized cannot be recycled until the sixth password change cycle).

We are developing a project that will address the Mainframe and OTPS password and complexity. The Mainframe and OTPS engineering teams will complete their respective projects, of updating their password requirements by 6/30/2018; to meet KPMG's recommended industry standard settings. When completed the Mainframe and OTPS systems will meet the same recommended industry standard settings.

System Access Revocation*

Observation

During our testing, it was noted that twenty three employees were not removed from their respective applications in a timely manner (five business days). Additionally, during our test work we noted that none of these twenty three employees accessed the network subsequent to their termination.

Recommendation

KPMG recommends removing terminated users application level access within 5 business days of effective termination date and that management update its policy to specify timeliness for terminations.

Management Response

As of August 4, 2017, PeopleSoft HR became the authoritative source for workforce members. Six times a day, a feed is drawn from PeopleSoft HR and Identity IQ processes that feeds and performs onboarding, off-boarding, updates to attributes, transfers and reinstatements. For each terminated employee or consultant an HR or Smart HR representative opens a Remedy SRM that notifies each of the application owners that a user has terminated, in order to meet the KPMG timeliness requirement.

Periodic Review*

Observation

During our testing, it was noted that there is no periodic review in place for the in-scope applications. While the match system provides a way for NYC Health + Hospitals to effectively monitor and terminate inactive accounts, KPMG found that it does not constitute as a 'User Access Review' because it does not provide any control over the levels of access each user has within the application.

Recommendation

KPMG recommends that management performs a periodic review of active users and user access rights to identify and remove inappropriate system access.

Management response

As part of the PeopleSoft HR and Identity Management systems (Identity IQ) project, we will be working with their teams, as well as the Payroll department personnel, on defining a methodology of assigning a manager(s) liaison for each of the user's system access identities, in order to create an audit reporting process. The audit report process would include producing periodic reports that would be provided to each of the assign managers /liaisons, for their review and validation. This will help to ensure each user has the correct access levels and avoid access

creep, that may occur when a user job assignment/responsibility changes. We will be working with the payroll departments and facility liaison's, in defining the correct contact personnel to provide the data to and will complete the process by March 31, 2018.

Tax Comment

Observation

Treasury Regulation 1.501(r)-4(b)(5) requires a hospital facility to provide information about its financial assistance policy (FAP) to patients via conspicuous written notice that informs the recipient about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP and FAP application process and the direct Web site address (or URL) where the copies of the FAP documents may be obtained. KPMG reviewed a sample billing, and noted it references HHC Options and provides a phone number, however the invoice should also provide the website address so patients can read about the FAP online.

Additionally, Treasury Regulation 1.501(r)-5(b) requires a hospital facility to limit the amount charged for care it provides to any individual who is eligible for assistance under its FAP to not more than the amounts generally billed (AGB) to individuals who have insurance covering such care, and AGB must be determined using one of two methods – the look-back method or the prospective method. Further, the regulations require the hospital facility's FAP to reference its chosen method. In conversations with NYC Health + Hospitals management, KPMG understands NYC Health + Hospitals has not formally adopted the prospective method, nor does it reference either method in their FAP as required by the Treasury Regulations cited above; however, management believes individuals eligible under HHC Options are never charged more than Medicare fee-for-service or Medicaid rates.

Recommendation

We recommend that NYC Health + Hospitals update their billing notices so that they not only include references to HHC Options and a phone number, but also include a website address so patients can read about the FAP online. Additionally, we recommend that NYC Health + Hospitals formally adopt the prospective method and reference it in the HHC Options policy.

Management response

While Management believes that the existing policies are compliant with New York State regulations, we have informed our billing vendor to add the web address so patients and others can have more information regarding the charity care policy. This process will roll out mid-January 2018. In addition, NYC Health + Hospitals will update the HHC Options policy in regards to Treasury Regulation(s) to describe the method utilized.

Status of Prior Years Comments

We noted several areas in which the prior year management letter recommendations were addressed by management. These comments and management's resolution status are listed below.

MetroPlus

Observation

The financial reporting process for NYC Health + Hospitals continues to be a complex process, which requires management to record and present the financial statements of its discretely presented component unit, MetroPlus within the NYC Health + Hospitals financial statements. The financial reporting process for MetroPlus requires timely communication between MetroPlus and NYC Health + Hospital's finance departments to ensure that all related-party transactions are appropriately reflected and that all subsequent events identified are evaluated and considered for potential recording and/or disclosure implications. During our audit, there were several audit and post-closing entries related to subsequent event information and related-party transactions between NYC Health + Hospitals and MetroPlus. As NYC Health + Hospitals reports its financial statements throughout the year on a quarterly basis and has a fiscal year-end audit that is different from the calendar year-end of MetroPlus, improved communication between the finance departments is important to ensure that the financial statements and account analysis is updated and recorded on a timely basis.

Recommendation

We recommend that management develop policies and procedures to ensure timely communication between the respective finance departments. In addition, the MetroPlus' finance department should ensure that its financial records are updated based upon the most recent information available.

Management Response

In order to improve communication between the MetroPlus and NYC Health + Hospitals finance departments, the following steps will be implemented immediately:

1. Meetings will be scheduled at least on a quarterly basis with key finance staff to review any significant subsequent events that need to be reflected on the financial statements for each entity.

2. All related-party account analysis will be performed and reconciled on a monthly basis after the first trial balance has been generated and made available by NYC Health + Hospitals. The completed account analysis will be reviewed and approved by responsible staff to ensure accuracy. Signed copies of the account analysis will be shared by each entity upon approval.

A summary schedule will be completed and signed by each entity to confirm that all related party and subsequent/significant items have been reviewed, discussed, and documented.

Managements Resolution Status

Representatives from the MetroPlus and the Corporate Comptroller's office have been meeting on a regular basis to discuss items of importance between the MetroPlus finance department and the Corporate Comptrollers division. During the year-end audit review, these meetings took place with more regularity than the quarterly reviews.

The related party account balances were agreed upon by both parties and documented accordingly utilizing a related party account summary worksheet, and will continue each and every quarter.

Fixed Asset Depreciation

Observation

During our fixed asset test work we identified two fixed asset additions (one in Morrisania and one in Lincoln) out of a sample of forty, which had depreciation expense recorded; however, the asset was not yet placed into service. This occurred because of a system process where purchases are automatically moved to fixed additions and begin depreciating upon payment to the vendor even though they have not been placed into service. Based on discussions with management, in order to move the asset to construction in progress (CIP), a manual entry must be made. However, in this case, no verbal communication occurred between the purchaser and the Controller's office, and thus, no entry was made. As a result, these two items began depreciating prior to being placed in service.

Recommendation

While the findings identified were not material to the financial statements, we recommend that management implement controls and update policies and procedures to ensure that deprecation of fixed assets is not recorded until the fixed asset is placed into service. Additionally, we suggest more frequent communication between the purchaser and the accounts payable department.

Management Response

Management agrees with the recommendation noted. Our current Legacy Financial System does not allow any facility to pay for an asset until it has been recognized as "tagged and assigned" in the OTPS system. Based on documentation received from the departments, the assets in question were inappropriately assigned in the OTPS system. To prevent this from reoccurring:

- Effective immediately, we will ensure that assets have been installed and are placed into service prior to assignment in the OTPS system. To accomplish this, no asset will be assigned in the OTPS system by the Fixed Asset Liaison until the Facility Controller has confirmed from the Department (owner of the Asset) that an Asset has indeed installed and placed into service. In the interim, for those assets that are to be assigned piecemeal, Construction in Process (CIP) accounts will be maintained off-line and final reclassification will be made in FAM to properly reflect full asset on books.

- We will request an adjustment of the Depreciation be done by Corporate Comptroller's Fixed Assets Management Department to reflect the actual date that the items were placed into service.

- In July 2017, PeopleSoft financials will go live throughout New York City Health + Hospitals. The Asset Management Module will require a four-way match on assets. This means that Assets will require the traditional three-way match for Accounts Payable plus an additional match for the inspector. PeopleSoft will also have an option to allow for payment of an asset regardless of its in-service status. Depreciation will only begin when the asset is placed into service. This will prevent Assets from being capitalized prior to being placed in to service.

Management Resolution Status

Additional training of Fixed Asset staff was conducted within the first half of fiscal year 2017 for the proper accounting of assets that have not been placed into service. Sampling of asset additions will be tested for determining adjustments, if necessary, to the asset addition to ensure consistency with GAAP.

Tax Comments

Observations

1. To maintain tax-exempt status under 501(c)(3), an entity is generally

    (a) Prohibited from intervening in any political campaign or on behalf of any political candidate

    (b) Limited in the amount of moneys it can expend on lobbying (attempts to influence legislation)

    (c) Prohibited from entering into any transaction with an insider at terms other than arm's length (this is called private inurement).

As it relates to MetroPlus, our audit review procedures have identified no prohibited campaign contributions or related campaign intervention, no material lobbying expenditures, and no instances of private inurement. Based upon our review of the final 2015 MetroPlus Form 990, MetroPlus reports paid staff as paid by MetroPlus; however, the return does not include a narrative to explain whether MetroPlus (or NYC Health + Hospitals) has a compensation review policy in place, which meets the rebuttable presumption of reasonableness.

1. In April 2014, NYC Health + Hospitals obtained tax-exempt status for its related entity Gotham Health. Based upon documentation reviewed to date, this entity is a separate entity for tax purposes, was tax-exempt under IRC Section 501(c)(3) and was a public charity recognized under IRC Section 509(a)(1). Exempt status was granted effective May 2, 2012; however, the exempt status was automatically revoked because it did not file Form 990 for three consecutive years. The automatic revocation is effective on the original filing due date of the third annual return or notice (May 15, 2015). Technically, Gotham Health has an annual IRS filing requirement with or without tax-exempt status; therefore, the effect of automatic revocation is that the entity is required to file Form 1120, U.S. Corporation Income Tax Return (due by the 15th day of the 3rd month after the end of the organization's tax year) and pay applicable income taxes. As an automatically revoked organization, Gotham Health is not eligible to receive tax-deductible contributions. It is possible for the tax-exempt status to be reinstated or retroactively reinstated.

Recommendations

1. Based upon our inquiries with management, we understand MetroPlus staff are paid employees of NYC Health + Hospitals and NYC Health + Hospitals has compensation review policies in place. We recommend the MetroPlus 2015 Form 990 reflect such policies.

2. We understand Gotham Health will be requesting retroactive tax-exempt status reinstatement prior to December 31, 2016 and we recommend management follow-up with the IRS in early 2017 to ensure the reinstatement request was received and complete.

Management Response

We will incorporate appropriate language in future Form 990 filings regarding Health + Hospitals compensation policy. The current policy is available for review.

Gotham's management worked with KPMG, Central Office Finance and Central Office Legal Department to complete and file IRS Form 990s for 2012–2015 and IRS form 1023 (Application for Tax Exemption). All forms were completed and signed by Gotham's Chief Financial Officer on Tuesday, November 22, 2016.

Management Resolution Status

MetroPlus has agreed to incorporate the appropriate language regarding their current compensation policy in the upcoming Federal Form 990 filing for calendar year 2016, which will be filed under extension and due November 15, 2017; however, the recommendation by KPMG to meet this requirement of filing within the 2015 Form 990 filing was not possible considering the timing of the Federal Tax filing date of July 21, 2016 and the issuance of this Management Letter report of December 8, 2016.

During the course of the year, the Gotham Health FQHC, Inc. (Gotham) Management team had notified NYC Health and Hospitals Comptroller's office that they were successful in their correspondence with the Internal Revenue Service (IRS) and had received notification that the tax-exempt status of Gotham has been re-instated. This was made possible by the work contributed by KPMG tax specialists in assisting the Gotham Management team in the filing of the federal tax form 990's for the years where the IRS had not received a previous filing. Gotham is currently up-to-date on their tax filings, and NYC Health + Hospitals Comptroller's office has been notified that Gotham has filed for an extension of time for the most recent tax return to be filed, which is now due to the IRS on November 15, 2017.

Industry Comments

Beyond Implementation: Optimizing Electronic Health Records to realize results

Many healthcare providers spent a significant amount of resource hours and multi-millions of dollars implementing electronic health record (EHR) systems. Many health care providers may not have been able to optimize their EHR systems and experience the value that the technology is designed to bring to healthcare. As such, optimizing EHR systems is a top priority in the short term. Healthcare organizations understand that developing and implementing a post-EHR implementation strategy under the support of a change-management model has become a key for success to optimizing EHR to realize results. Establishing a long term approach that seeks to achieve incremental changes in processes in order to improve efficiency and quality through the use of technology in order to create more value in the quality of care provided to patients as well as value received by the healthcare provider. When such an approach is adopted, clinicians and other staff will actually change their processes to optimally align with the technology. Without change management, the EHR operates in a silo and doesn't align with the way clinicians practice medicine or with new industry demands, which creates dissatisfaction and underutilized technology. Overall, organizations recognize that optimizing EHRs deliver value by leveraging data to drive strategic decisions, improve patient care, and control costs.

While we did not perform a review of the policies and processes management has in place with respect to a post-implementation review of EHR, we recommend the following leading practices be considered if not already contemplated:

1. Assemble a cross-functional team that comprises technology professionals as well as clinical and business leaders to focus on executing an EHR post-implementation strategy and aligning it with the organizational goals.

2. Management should continue to invest in data and analytics (See Data and Analytics Comment) as a key to providing insight into performance. The ability to understand and share information can assist in the process of implementing other technological tools such as telehealth, mobility, and virtual care. These digital technologies extend the reach of the clinician for the benefit of the patient.

Navigating change across the care continuum

Healthcare organizations are under economic pressure to shift from 'volume to value' and be in a position of improving clinical outcomes throughout the care of continuum at a lower cost. Health systems today are challenged by a fragmented delivery system that is not sustainable from a quality and cost standpoint. There are several reasons for this:

1. Delivery of care has been centered around the provider rather than the patient

2. Care has been delivered inconsistently, with highly variable outcomes clinically, operationally, and financially

3. Providers have operated in silos which lack coordination across the full care continuum

Systems will be required to transition from the current system to one which focuses on the patient journey through the entire care continuum. Providers will be measured on the total cost of care through this continuum, and payments will move from a reflection of activity, to a system where quality clinical outcomes drive reimbursement. Total cost of care comprises the inclusive payments for the complete gamut of health care services utilized by a patient or population including Ancillary, Inpatient, Outpatient, Pharmacy, and Professional activities. Providers will need to work together to reduce total costs and provide sufficient services for the complexity of patient needs.

We recommend that management continue to focus on partnerships, networks and alliances (inside and outside of their organization) to deliver value in the care continuum and reduce unnecessary variation in care.

Additionally, management should continue to invest in data and analytics to help link the data in both a patient and disease centric ways across the treatment continuum to provide clarity as to the root causes of issues and identify opportunities for clinical improvement. Clinically led improvements includes designing and implementing standards of care that embody evidenced based clinical pathways, creating sets and protocols, and monitoring metrics to drive improvements in the treatment of specific patient populations.

It is also recommended that management consider implementing a delivery performance monitoring, and true reporting and accountability systems for physicians, nurses, and ancillary providers to provide evidence- based, medically-appropriate care at improved timing and cost.

Balancing the enterprise –Containing costs and risk while improving safety

Finance, procurement, and supply chain executives are always looking to reduce costs, while the clinical side of a business is focused on providing safe and effective care at a reasonable cost. Is there a way to balance these competing goals?

While an emphasis on quality of care and process standardization have dramatically increased, rising costs and lower revenue are an escalating challenge. This challenge has created a growing need for more productive workflows related to clinical and life safety support. Many organizations are moving toward adopting an enterprise asset management strategy (EAM). An EAM provides accurate physical, financial, and contractual asset information that informs enterprise-wide business decisions, which ultimately results in better risk management, cost management, patient safety, and operational efficiencies.

An effective EAM can enhance an organizations ability to manage inventory, keep preventative maintenance work on a predictable schedule, and produce management reports that are required for safety and risk reporting compliance and as a result may experience the following benefits:

- Reduced oversubscription of vendor maintenance contracts

- Ensured efficient asset utilization across the enterprise

- Improved regulatory compliance on equipment and life safety devices, leading to improve patient safety

- Aligned vendor/manufacture warranty and maintenance schedules

- Standardize workflow processes and management of enterprise work orders

We recommend that management consider the following five strategies for an effective enterprise asset management strategies:

- *Identify ways to contain or even reduce costs* – Are there vendor maintenance support contracts in place that are not necessary or could be modified for the coverage needed? Are there contract in place that are duplicative?

- *Improve patient safety through compliance with regulatory and safety programs* – Don't wait for a patient safety event to occur before correcting reported issues with equipment. Be proactive with scheduled preventative maintenance.

- *Use management reporting tools effectively* – Are there tools in place that capture equipment usage, downtime and productivity, recalls, estimated end of life usage, etc.?

- *Improve the System's ability to provide support and excellent customer service* – Consider establishing processes that help your staff trained technicians to meet service level agreements, provide appropriate project management services and value in repurposing assets.

- *Consider how this would impact the overall budgeting process* - Comprehensive, reliable data on assets, staffing, contract support and services is the key to creating a budget that meets your organization's financial requirements. Real-time analytics and forecasting for future asset management programs allow realistic budgeting that covers all current and projected costs.

Medicare Access and CHIP Reauthorization Act (MACRA)

With the passage of the final rule for MACRA in October 2016, physicians and certain other clinicians will begin to be paid for Medicare Part B based on the Quality Payment Program (QPP) starting in 2019 which will analyze performance data from 2017. Payment will now be linked to clinician performance, provide options for physicians to choose a path to alternative payment bonuses and penalties, and encourage the adoption of value based payment options. Physicians and other clinicians will earn payment adjustments based on performance in four categories linked to quality and value or through participation in programs with base payments related to quality measures. Furthermore upon enactment, MACRA repealed the Sustainable Growth Rate formula and replaced it with a stable 0.5 percent payment update through 2019 as part of the QPP.

As providers and health systems prepare for QPP payment adjustment beginning in 2019 they must consider which payment option will be the most beneficial for their organization considering experience and willingness to bear increasing financial risk, current level of care coordination, existing health IT and data infrastructures, patient population demographics and health status and local market influences and factors. Furthermore, all providers will need to better understand their performance in relation to others and be prepared to implement practice transformation strategies aimed at improving quality and reducing costs.

Cyber Security – Medical Devices

Cyber Security continues to be an important concern for every organization. The frequency and severity of medical device risks are escalating as devices proliferate and cyber-attacks turn their attention to vulnerable environments. In addition to the recent wave of "ransomware", whereby threat actors use malware to encrypt information in comprised environment and demand digital currency to unlock information and restore operations, health care organizations face a wide variety of cyber threats, which vary in sophistication.

Medical devices are often vulnerable to cyber-attacks and contribute to the likelihood that not only the device itself, but critical health care services or an entire organization, will be comprised. Medical devices are ripe targets for cyber threats due to a combination of two factors 1) new technology-enabled, and interconnected medical devices open up new attack vectors 2) older medical devices are often not secure and poorly managed.

In addition to these two factors, devices that are configured to connect with another device, advance their risk of an attack. These risks are expected to multiply as organizations and consumers continue to interface systems and networks to transmit information. These interfaces include wearable technologies, smart computing devices, and programs such as EPIC which transmits patient data to different sources over multiple networks.

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. It is also about understanding and documenting how vulnerabilities could potentially impact medical devices, the organization, and most importantly the patients served and establishing programs, processes, and controls, to address such risks.

- 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, to understand the attacks total scope, 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. The organizations should also be prepared to understand the scope of the attack, as well as focus on preserving and collecting evidence. The organization should ensure protocols exist to allow patient care to continue without interruption. 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 NYC Health + Hospitals communicate and work collaboratively with members of their supply chain (from manufacturers to health care providers) to actively identify cyber risks and related threats, plan for mitigation and remediation, and ensure the ongoing safety and security of patients. During this process, organizations should continue to assess if they have an adequate approach to cyber security, including cyber security risks as it relates to medical devices. The organization should also assess if preparations for a security event and the ability to prevent or minimize the impact of an event has been addressed.

A Dual Evolution: Payment Reform and Telemedicine *

Telemedicine has been identified as a catalyst for the transformation of healthcare systems from fee-for-service to a value based purchasing (VBP) system. Telemedicine is the use of telecommunication to provide clinical health care at a distance. With the introduction of any new technology, both benefits and uncertainties exist. Telemedicine eliminates distance barriers and provides better population health management for both the chronically ill and the underserved. In the upcoming VBP environment, providers will be incentivized to minimize outcomes and manage costs. Telemedicine offers greater physician and care setting choices at a fraction of the cost. The combination of accessibility and affordability creates an environment around continuity of care, which encourages providers to track patient's progress long term to improve outcomes. In addition to the millions of people who entered the healthcare system with the passage of the ACA, the number of people needing health care is expected to quadruple by 2050. By 2025, Millennials are expected to account for 41 percent of healthcare spending. Therefore, it is imperative that provider organizations create quicker and easier ways to see patients and consider the influence and preference of Millennials.

We recommend that management consider evaluating the benefits of telemedicine whether to meet the needs of discerning consumers, improve outcomes and population management, or facilitate continuity of care. During the transition from fee-for-service to value-based purchasing, we believe telemedicine can be an important tool to attract new patients, retain current ones, and engage patients with tools and personal information that can influence treatment adherence, improve outcomes and encourage self-management of care.

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 healthcare 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 five-year period. As the program continues, the eligibility requirements will continue to be more challenging as the requirements become more focused on pay for performance metrics over the next several years of the DSRIP program.

The five-year DSRIP period began April 1, 2016. During the five-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 predefined 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 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 semiannual 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 pay for reporting or pay for 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 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 continue to be engaged in the process and understand the risks and benefits so they can effectively steer the organization through the changes to come.

Digital Transformation and Robotics

Innovation in technology is growing at an increasingly rapid pace, regardless of industry, where organizations are moving beyond the management of structured data and manual analysis to much larger data sets and automated analysis of unstructured data.

Through cloud based applications, robotics, workplace automation, cognitive technology and other advances, organizations can manage information more effectively than ever before. These new innovations can recognize patterns, identify outliers and anomalies and perform predictive analysis with greater speed, accuracy and efficiency than technologies that were available just a few years ago.

Cognitive technology and data and analytics when used together can generate greater analytical depth, broader perspectives and ore effective decision making than ever before.

Forward thinking healthcare organizations are also starting to explore robotic process automation (RPA) in the revenue cycle. RPA can be used with data and rule-based processes to replace or supplement repetitive task normally handled by humans. Given the large percent of healthcare claims that result in edits or exceptions which can lead to denials, RPA can help identify issues, facilitate claims review, and quantify and categorize past denials. This could enable healthcare providers to recoup these denials. Additionally, RPA can be used to assist in the management and resolution of accounts from preregistration and appointment scheduling to the final payment of a bill.

Management should consider the use of digital technology moving forward to allow for certain repetitive tasks to be done more effectively and efficiently, eliminating the risk of error, and allowing for work to be done around the clock. Additionally the use of digital technology, will allow management to better balance time and resources, so that internal staff can shift their focus to core business activities, potentially allow for a reduction in payment delays and denials in order to reduce the delays in cash flow timing, as well as allow for better analytical review.

Tax Reform

Given the ongoing discussion of tax reform at the federal level and the separate tax overhaul bills from the House of Representatives and the Senate finance committee, NYC Health + Hospitals should continue to monitor the potential impacts to the organization, particularly the discussions surrounding unrelated business income tax and the potential impacts it may have on the organization. This monitoring should also include modeling out the financial impact of the various provisions and potentially working with trade associations to mitigate the potential negative impacts of certain provisions on the organization.

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Our audit procedures are designed primarily to enable us to form an opinion on the financial statements and, therefore, may not bring to light all weaknesses in policies or procedures that may exist. We aim, however, to use our knowledge of the NYC Health + Hospital's organization gained during our work to make comments and suggestions that we hope will be useful to you.

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

The Company's response to our communication of the deficiencies and other matters identified in our audit is described above. NYC Health + Hospitals responses were not subjected to the auditing procedures applied in the audit of the financial statements, and accordingly, we express no opinion on the responses.

The purpose of this letter is solely to describe comments and recommendations intended to improve internal control or result in other operating efficiencies. Accordingly, this letter is not suitable for any other purpose.

Very truly yours,

KPMG LLP