

AUDIT COMMITTEE
MEETING AGENDA

June 09, 2016

11:00 A.M.

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

CALL TO ORDER

Ms. Emily A. Youssouf

- Adoption of Minutes April 12, 2016

Ms. Emily A. Youssouf

ACTION ITEMS

INFORMATION ITEMS

- KPMG 2016 Audit Plan
- Audits Update
- Compliance Update

Ms. Maria Tiso

Mr. Chris A. Telano

Mr. Wayne McNulty

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: April 12, 2016

TIME: 2:30 PM

COMMITTEE MEMBERS

Josephine Bolus, RN

Mark Page

OTHER MEMBERS OF THE BOARD

Dr. Lilliam Barrios-Paoli

STAFF ATTENDEES

Antonio Martin, Executive Vice President/COO

Salvatore Russo, General Counsel, Legal Affairs

Ross Wilson, Senior Vice President, Chief Medical Officer

Maureen McClusky, Senior Vice President/Post-Acute/LTC

Steven Bussey, Chief of Ambulatory Care

Randall Mark, Chief of Staff, President's Office

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

Julian John, Corporate Comptroller

Gassenia Guilford, Assistant Vice President, Finance

Kathleen Whyte, Senior Director, Intergovernmental Relations, Central Office

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

Wayne McNulty, Corporate Compliance Officer

Devon Wilson, Senior Director, Office of Internal Audits

Carol Parjohn, Director, Office of Internal Audits

Carlotta Duran, Assistant Director, Office of Internal Audits

L. R. Tulloch, Senior Director, Office of Facility Development

Ronald Townes, Associate Director, NYC H + H/Kings County

Elsa Cosme, Chief Financial Officer, NYC H + H/Gouverneur

Kim Walcott, Coordinating Manager, NYC H + H/Coney Island

OTHER ATTENDEES

PAGNY: David N. Hoffman, Compliance Officer

KPMG: Peter Schermerhorn, Director of Healthcare Advisory

APRIL 12, 2016
AUDIT COMMITTEE MEETING
MINUTES

An Audit Committee meeting was held on Tuesday, April 12, 2016. The meeting was called to order at 2:30 PM by Dr. Lilliam Barrios-Paoli, Board Chair, acting as Committee Chair on behalf of Emily Youssouf who was excused.

Dr. Barrios-Paoli asked for a motion to adopt the minutes of the Audit Committee meeting held on February 11, 2016.

Dr. Barrios-Paoli introduced the first action item by stating that Mr. Chris Telano, will read a proposed resolution.

Action Items:

Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with Loeb & Troper, LLP, CPAs for annual financial and compliance audits of 22 Corporation auxiliaries. This contract is for audit services for calendar years 2015 to 2017 with two separate one-year renewal options in an amount not-to-exceed \$855,000. The Corporation at its sole option and discretion may renew this agreement for an additional one or two successive one-year terms.

Dr. Barrios-Paoli asked if there were any questions.

Mrs. Bolus answered that the only thing she found problematic the timing of the resolution being presented. It was agreed any time any contract came within six months, we would review it at least six months in advance. This one ended in December 2015.

Mr. Martin agreed but thought that the caveat only pertained to real estate.

Mrs. Bolus added "for anything".

Mr. Martin stated his apologies. He recalled the discussion surrounding real estate; however, going forward, we can make sure to bring others at or before the six-month timeframe as well.

Mr. Telano asked if they would like the representative from Loeb & Troper to come to the table.

Dr. Barrios-Paoli answered sure.

The representatives introduced themselves as follows: Mr. Gary Kamath, Partner; Mr. Eric Goldfarb, Partner and Ms. Carol Parjohn, Director of Internal Audits.

Dr. Barrios-Paoli asked if anybody had any questions or concerns. For the purpose of full disclosure, when I ran a not-for-profit many years ago, my auditor was Loeb & Troper, and I was happy.

Mr. Telano stated that just to make a couple of points is that each auxiliary is required to have an annual audit of its financial statement per Operating Procedure 10-20, and each auxiliary must be separately incorporated and registered under New York State Law, and their goal is to enhance facility and patient care. Just to bring up some numbers, for calendar year 2014, which is the last year we have data available, the revenues range from a low of \$12,000 at Harlem Hospital to a high of \$1.4 million for the Children of Bellevue Auxiliary. Please note that the VENDEX approval is pending.

Mrs. Bolus asked if we have any way of educating the person who gets elected to be chair of the auxiliary or whoever on bookkeeping. Is there a requirement for anyone within Bellevue or any other auxiliary?

Mr. Martin responded that in my experience it really depends. Some auxiliaries we try to bring on a bookkeeper or accountant type to be part of the auxiliary. Others will go out and hire an accountant or a bookkeeper to do the books for them. It is the two methods that I have seen at the facilities.

Dr. Barrios-Paoli asked if there were any other questions, do I have a motion for approval.

Mr. Page asked if the resolution was for a renewal of the contract. To which Mr. Telano responded that this is a renewal, they also were the auditors for the last five years.

Mr. Page then asked do you find that you are actually doing the accounts for the auxiliaries, or are you auditing accounts that they put together for you?

Mr. Kamath answered that they do hire outside accountants to do their own books. A lot of them have some good books. We do prepare the financials for them and usually we expect the clients to verify the financials because it is their responsibility, but more or less we do prepare the financials, but they do review that internally and internal audit reviews the books also before it is finalized.

Dr. Barrios-Paoli asked for a motion to approve. It was duly seconded and unanimously approved.

Mr. McNulty saluted and introduced himself as Wayne McNulty, Chief Compliance Officer and Senior Assistant Vice President and read the following resolution into the record:

Adopting the New York City Health and Hospitals Corporation (hereinafter "NYC Health + Hospitals" or the "System") Principles of Professional Conduct (POPC), which as required pursuant to 18 NYCRR Section 521.3(c)(1), and as recommended under the US Department of Health and Human Services Office of the Inspector General Compliance Program Guidance to Hospitals (1998) and the US Sentencing Commission Guidelines (2015), sets forth in writing NYC Health + Hospitals' compliance expectations and commitment to comply with all applicable federal and state laws.

Paraphrasing from the executive summary, he stated that the POPC is a guide that sets forth NYC Health + Hospitals' compliance expectations and commitment to comply with all applicable federal and state laws. It describes NYC Health + Hospitals' standards of professional conduct and efforts to prevent fraud, waste and abuse. The POPC also serves as the formal "Standards of Conduct," also often referred to in the compliance and governance community as a "Code of Conduct" or "Code of Ethics", for NYC Health + Hospitals.

The legal requirements under Social Services Law 363-d and 18 NYCRR Part 521 is as part of our participation in the Medicaid program, New York State's mandatory provider compliance program regulations requires a condition of participation that NYC Health + Hospitals is required to establish and maintain an effective compliance program, which includes, among other things, the development and promulgation of written policies and procedures that describe compliance expectations embodied in a code of conduct or code of ethics. Additionally, under the Federal Sentencing Guidelines similar to Part 521, the Federal Sentencing Guidelines also require that organizations put together a standard of conduct.

We have an existing POPC, and we are now updating that existing POPC. The updated POPC outlines Health + Hospitals compliance expectations and mandates that all NYC Health + Hospitals workforce members, and workforce members includes trainees, volunteers, all medical staff members, all Health + Hospitals employees, all Board of Directors, any affiliates, and business partners affirmatively participate in NYC Health + Hospitals Corporate Compliance and Ethics Program that underscores the types of practices and conduct that are prohibited. It sets a tone from the top to establish the importance of compliance and protects whistleblowers from retaliation.

Mr. Page stated that in your reading, you mentioned the Board of Directors. However, it is not actually written.

Mr. McNulty stated that it is on page ten, the definition of "workforce members".

Then Mr. Page asked why it wasn't listed on page five as well. To which Mr. McNulty responded that we can do that as well with the resolution going forward.

As mentioned before, the POPC sets the guide for the Corporation, for the System to make sure they have the standards of a professional conduct, and Section II it goes forward with who the POPC applies to. In Section II it states that it applies to workforce members, whether permanent or temporary, and including all NYC Health + Hospitals employees, students, trainees throughout NYC Health + Hospitals' facilities, units and entities.

It also applies to NYC Health + Hospitals business partners who are required by law or contract to comply with this POPC, including POPC's core objectives specified in Section III below.

Business partners include OneCity Health/Delivery System Reform Incentive Payment Program -- it applies to all contractors, subcontractors, agents and other persons or entities that on behalf of NYC Health + Hospitals provides billing and coding functions, furnishes healthcare services or items or monitors the healthcare provided by NYC Health + Hospitals. As you look at the core objectives, the first bullet, it sets forth our mission and the principles of professional conduct, and if you turn to page 11, it goes through the principles, the guiding principles and makes sure that's covered also in principles of professional conduct. It discusses to prevent, identify and correct unlawful and unethical behavior, and in also the last bullet on that page, deliver high quality, medically necessary care and services for all individuals specifically to ensure that only healthcare professionals and other health professionals who are duly licensed, certified, credentialed or otherwise qualified in accordance with federal and state law, medical staff bylaws and associated rules and internal policies are authorized to deliver care to patients.

Continuing, the key point that was missing in the existing principles of professional conduct is to maintain a respectful, healthy and productive, safe, work environment with the goals of preventing discriminatory and other inappropriate forms of conduct reducing the likelihood of illnesses and injuries and helping workforce members realize their full potential.

That includes provide equal employment opportunities for all workforce members and all employment candidates regardless of any protected characteristic including without limitation race, age, gender, gender identity, sexual orientation, religion, ethnicity, disability or any other protected class covered federal, state and local anti-discrimination laws, to promptly respond and address all acts and threats of violence, intimidation, discrimination or harassment or disruptive behavior, to encourage workforce members to realize their full potential, to provide reasonable accommodations to workforce members with disabilities, and to perform initial and periodic health screenings of all workforce members as required applicable law and internal policies and procedures.

The POPC prohibits and promptly reports to all appropriate parties allegations of retaliation, harassment or intimidation in response to workforce member, business partner or other stakeholder participation in the Corporate Compliance Program. The Corporate Compliance Program will not work effectively if we do not have firm anti-retaliation policies, and we have established that throughout the System, and we take that very seriously.

The workforce member responsibilities under the principles of professional conduct is to not engage in any act of conduct that would be contrary to any of the System's core objectives that we just went over in Section III, not engaging in any unprofessional conduct, fully cooperating with any internal or government investigation, and reporting any event, occurrence, activity or other incident that appears to violate applicable law or NYC Health + Hospitals policies and procedures.

The business partners have similar responsibilities, as the workforce members. They must either adopt a code of conduct that is substantially similar to our code of conduct, and they cannot engage in any act that is contrary to our code of conduct or that interferes with us carrying out our core compliance objectives, and lastly they can't engage in any conduct that's considered professional misconduct, which is listed on page 15, Section VI.

To highlight a couple of key areas: improper billing practices including upcoding, submitting multiple claims for a single service or submitting a claim to more than one primary payor at the same time, unbundling, submitting claims in a piecemeal or fragmented way to improperly increase payment.

Any violation of state human subject research laws or NYC Health + Hospitals Human Subject Research Protections Program Policies and Procedure.

If you violate the principles of professional conduct of any NYC Health + Hospitals policies or procedures, workforce members and business partners would be subject to disciplinary action, fair and firm disciplinary action, including termination of employment contract or other affiliation with Health + Hospitals as applicable.

Section VIII describes how to report violations of policies and procedures or applicable law under the POPC, and Section IX on page 17 is what we discussed earlier about the prohibition of retaliation and for whistleblower protection.

Lastly on Section X is some informational items for workforce members to stay informed about the NYC Health + Hospitals policies related to Corporate Compliance Program. So the next steps is that we will present this if the Committee here adopts this resolution to present this to the full Board of Directors and then the Office of Communication and Marketing, and they are going to brand this document and create this in pamphlet file to distribute it to the workforce members. We will include this in all new employee orientation and all continuous compliance education. We will be going out to the facilities, outreach through our Compliance Departments to speak to all employees throughout the facilities, and we are going to take this document and reduce it to a one-page, plain English version and also facts and questions that can go out to the employees, a simplified version of this.

Mr. McNulty asked if there are any questions about the principles of professional conduct.

Dr. Barrios-Paoli asked for a motion to approve the resolution. It was unanimously approved with the recommended changes put forth by Mr. Page.

There being no other business, the meeting adjourned at 2:46 P.M.



Our mission is your health

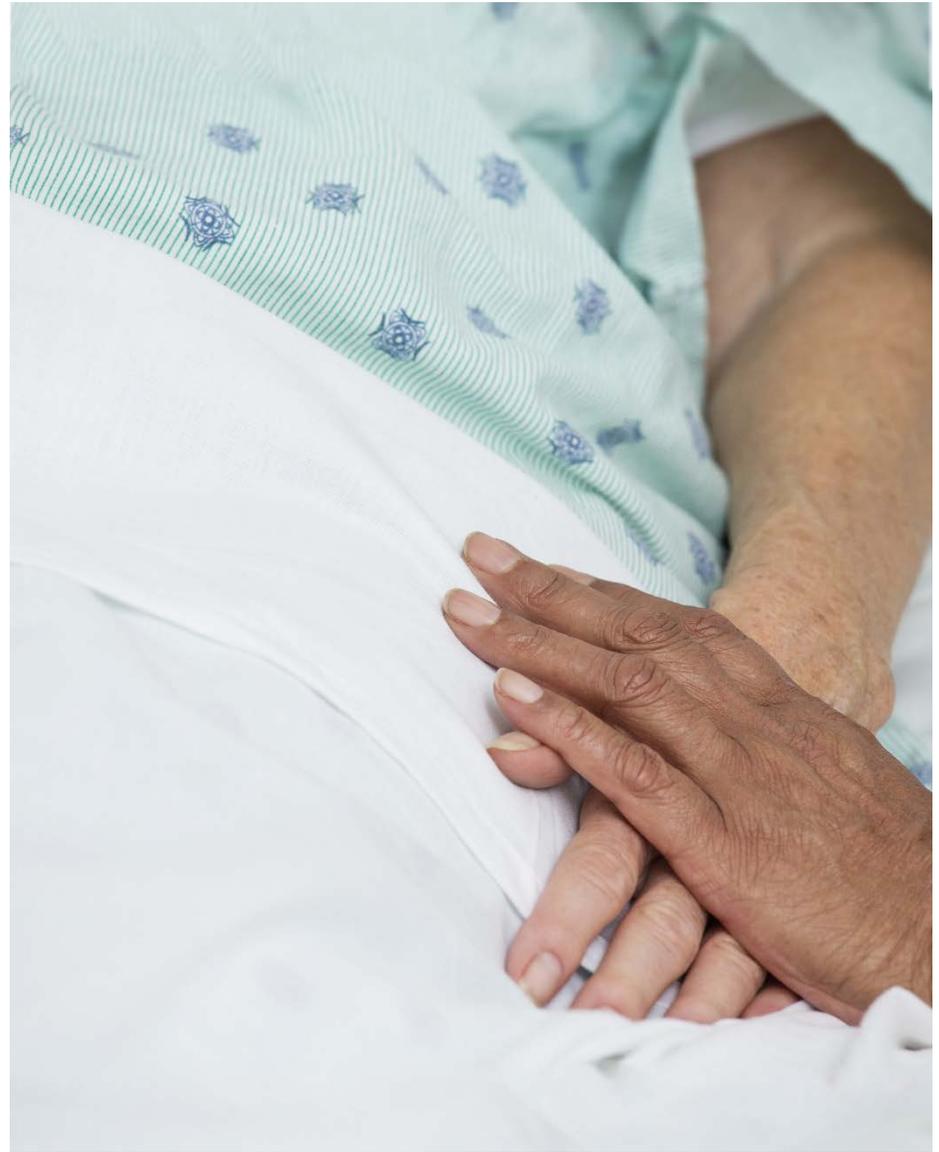
**NYC Health + Hospitals
Presentation of the 2016 Audit Plan to the Audit Committee**

June 9, 2016



Agenda

- 1.0 KPMG engagement team**
- 2.0 Deliverables**
- 3.0 Objective of an Audit**
- 4.0 Responsibilities**
- 5.0 Independence**
- 6.0 Financial Statement Audit Timetable**
- 7.0 Audit Matters**
- 8.0 Planned use of MBE / WBE/ Internal Audit**
- 9.0 General Considerations – Fraud Approach**
- 10.0 Planned SAS 99 Fraud Interviews**
- 11.0 Other Considerations**
- 12.0 New Accounting Pronouncements**
- 13.0 Audit Committee Resources**



KPMG Engagement Team

Engagement Team

- Maria Tiso – Lead Engagement Partner
- Mike Breen – Engagement Partner
- Sean Egan – MetroPlus / HHC Insurance Company Partner
- Joseph Bukzin – Lead Senior Manager
- Chris Dominianni – Senior Manager
- Beatriz Mendoza – Manager
- Dorothy Wright – HHC Insurance Company Manager
- Allison Cohen – Lead Senior Associate
- Marlee Fisher – Senior Associate

Other Resources

- BCA Watson Rice Staff – Minority Business Enterprise
- Healthcare Management Solutions Staff – Women's Business Enterprise

Subject Matter Professionals

- Felicia Tucker – Principal, Tax
- Devin Duncan – Manager, Tax
- Robert Mishler – Senior Manager, Actuary
- Peggy Hermann – Director, Actuary
- Anthony La Rocca – Director, IT

Other Partners and Managing Directors

- Jim Martell – Healthcare Resource Partner
- Steve Reader – Concurring Review Partner
- Renee Bourget-Place – MetroPlus Concurring Review Partner
- Rich Catalano – HHC Insurance Concurring Review Partner
- John Hawryluk – Healthcare DPP Liaison
- Mark Jamilkowski – Managing Director, Insurance Resource

KPMG Deliverables and Other

Auditor's Report on the financial statements of:

- NYC Health + Hospitals (NYC H+H or the Corporation)
- MetroPlus Health Plan (calendar year-end)
- HHC Insurance Company, Inc. (calendar year-end)
- HHC ACO, Inc.

Management letter to the Audit Committee and management on our recommendations regarding internal controls and other operational matters

Auditor's report on the cost reports for:

- Diagnostic and Treatment Centers
- Skilled Nursing Facilities
- Long-Term Home Health Care Program

Annual Debt Compliance Letter

Other:

- Provide up to 250 hours of tax advisory services over the contract period, which represents approximately \$145,000 of professional services at our standard rates.
 - 140 hours left for the contract period
- Provide five full days of continuing professional education (CPE) for up to 140 attendees per year

Objective of an Audit

- The objective of an audit of the financial statements is to enable the auditor to express an opinion about whether the financial statements that have been prepared by management with the oversight of the Audit Committee are presented fairly, in all material respect, in conformity with generally accepted accounting principles (GAAP)
- We plan and perform the audit to obtain reasonable assurance about whether the financial statements taken as a whole are free from material misstatement, whether from error or fraud.
- Our audit includes
 - Performing tests of the accounting records and such other procedures, as we consider necessary in the circumstances, based on our judgment, including the assessment of the risks of material misstatement to provide a reasonable basis for our opinion(s)
 - Evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, and evaluating the overall presentation of the financial statements

Responsibilities

Management is responsible for:

- Adopting sound accounting policies
- Fairly presenting the financial statements, including disclosures, in conformity with GAAP
- Establishing and maintaining effective Internal Control Over Financial Reporting (ICFR), including programs and controls to prevent, deter, and detect fraud
- Identifying and confirming that the Corporation complies with laws and regulations applicable to its activities and for informing the auditor of any known material violation of such laws and regulations
- Making all financial records and related information available to the auditor
- Providing unrestricted access to persons within the entity from whom the auditor determines it necessary to obtain audit evidence
- Adjusting the financial statements to correct material misstatements
- Providing the auditor with a letter confirming certain representations made during the audit that include, but are not limited to, management's:
 - Disclosure of all significant deficiencies, including material weaknesses, in the design or operation of internal controls that could adversely affect the Corporation's financial reporting
 - Acknowledgement of their responsibility for the design and implementation of programs and controls to prevent, deter, and detect fraud
 - Affirmation that the effects of any uncorrected misstatements aggregated by the auditor are immaterial, both individually and in the aggregate, to the financial statements taken as a whole

Responsibilities (continued)

The Audit Committee is responsible for:

- Oversight of the financial reporting process and oversight of ICFR
- Oversight of the establishment and maintenance by management of programs and internal controls designed to prevent, deter, and detect fraud

Management and the Audit Committee are responsible for:

- Setting the proper tone and creating and maintaining a culture of honesty and high ethical standards

The audit of the financial statements does not relieve management or the Audit Committee of their responsibilities.

Responsibilities (continued)

KPMG is responsible for:

- Forming and expressing an opinion about whether the financial statements that have been prepared by management, with the oversight of the Audit Committee, are presented fairly, in all material respects, in conformity with GAAP. Our audit is designed to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.
- Planning and performing the audit with an attitude of professional skepticism
- Conducting the audit in accordance with professional standards and complying with the Code of Professional Conduct of American Institute of Certified Public Accountants, and ethical standards of relevant CPA societies and relevant state boards of accountancy
- Evaluating ICFR as a basis for designing audit procedures, but not for the purpose of expressing an opinion on the effectiveness of the entity's ICFR
- Communicating to management and the Audit Committee all required information, including significant matters
- Communicating to the Audit Committee and management in writing all significant deficiencies and material weaknesses in internal control identified in the audit and reporting to management all deficiencies noted during our audit that are of sufficient importance to merit management's attention. The objective of our audit of the financial statements is not to report on the Corporation's internal control and we are not obligated to search for material weaknesses or significant deficiencies as part of our audit of the financial statements.

Independence

KPMG maintains a comprehensive system of quality controls designed to maintain our independence:

- Pre-approval of all worldwide engagements by audit engagement team through Sentinel, a KPMG independence verification system
- Monitoring employment relationships
- Tracking partner rotation requirements using PRS, the firm's automated partner rotation tracking system
- Automated investment tracking system used by all KPMG member firms (KICS)
- Training and awareness programs
- Compliance testing programs
- Annual reporting to the Audit Committee

Financial Statement Audit Timetable

NYC H+H:

May – June 2016

- Hold planning meeting with management
- Determine audit strategy
- Identification of audit focus areas
- Hold audit team planning meeting
- Review of December 31, 2015 and March 31, 2016 internal financial statements
- Communicate with management regarding IT related procedures
- Test IT General Controls
- Present 2016 Audit Plan to Audit Committee

June to July 2016

- Identify financial statement and assertion level fraud risks
- Perform test of operating effectiveness/design of controls
- Perform substantive audit procedures relative to interim account balances, including review of patient accounts receivable valuation utilizing data and analytics tool
- Review of non-routine transactions through June
- Perform SAS 99 fraud inquiry meetings
- Complete interim testwork at various facilities and Central Office, which will include testing controls over various processes such as patient accounts receivable, procurement, payroll/HR, and fixed assets.

Financial Statement Audit Timetable (continued)

August – October 2016

- Final phase of year-end audit begins July 11, 2016 through October 7, 2016
- Perform remaining substantive audit procedures
- Perform procedures to roll forward interim account balances to year end
- Perform SAS 99 fraud inquiry meetings
- Financial statement audit closing meetings with management
- Form audit conclusions
- Discuss key issues and deficiencies identified with management (provide draft management letter)
- Attend Audit Committee meeting to review draft financial statements, debt covenant compliance letter and perform required communications
- Finalize and issue audit opinion on financial statements

December 2016

- Present final management letter to Audit Committee

Financial Statement Audit Timetable (continued)

Other:

December 2016– January 2017

- Perform interim testwork for MetroPlus Health Plan audit

February – March 2017

- Final phase of MetroPlus Health Plan audit and issuance of financial statements

April – August 2017

- Issue auditor's reports on cost reports for the skilled nursing facilities (RHCF-4), diagnostic and treatment centers (AHCF) and long-term home health care facility (LTHHC)
- HHC Insurance Company audit and issuance of financial statements
- HHC ACO, Inc. audit

Audit Matters

We identify audit matters that could have a material impact on the Corporation's financial statements. We then consider these matters when developing our audit approach and tailor our procedures to address these risks.

Significant Audit Areas

- Valuation of patient accounts receivable
- Third-party and pools receivables/liabilities
- Postemployment benefit obligation other than pension (OPEB)
- Pension obligation
- Valuation of MetroPlus claims payable
- Liquidity

Other Audit Areas

- Patient accounts receivable (completeness, existence and accuracy)
- Related party transactions

Audit Matters (continued)

Significant Non-routine Transactions / Other Items

- Delivery System Reform Incentive Payment (DSRIP) Program
- Upper Payment Limit (UPL) funding from CMS and NYS
- EPIC implementation costs

Information Technology Matters

- General information technology environment
- Review and test IT access controls
- Review and test the controls over changes to the IT system
- Verify that the Corporation's detection controls are functioning as intended
- Inform management of any performance improvement observations

Planned Use of Minority Business Enterprise, Women's Business Enterprises and Internal Audit

KPMG plans to utilize the Minority Business Enterprise (MBE), Women's Business Enterprise (WBE) and Internal Audit in the following areas:

	<u>MBE</u>	<u>WBE</u>	<u>Internal Audit</u>
Third party payor liabilities		X	
Site visits	X		X
Grants receivable / Grant revenue	X		
Capital assets	X		
Cash			X
Investments/Assets limited as to use	X		
Human Resources/Payroll	X		
Debt			X
Accounts payable and expenses			X

General Considerations – Fraud Approach

Identification of fraud risks

- Perform risk assessment procedures to identify fraud risks, both at the financial statement level and at the assertion level
- Discuss among the audit team the susceptibility to fraud
- Perform fraud inquiries of management, the Audit Committee Chair and others
- Evaluate broad programs/controls that prevent, deter and detect fraud

Response to identified fraud risks

- Evaluate design and implementation of antifraud controls
- Address revenue recognition and risk of management override of controls
- Perform specific substantive audit procedures (incorporate elements of unpredictability)
- Evaluate audit evidence
- Communicate to management and the Audit Committee

Planned SAS 99 Fraud Interviews

We plan to perform the following SAS 99 fraud interviews for the annual audit ending June 30, 2016:

Emily Youssouf – Audit Committee Chair

Dr. Ramanathan Raju – President and CEO

Plachikkat V. Anantharam - Senior Vice Present, Finance and CFO

Wayne McNulty – Senior Assistance Vice President, Chief Corporate Compliance Officer

Antonio Martin – Executive Vice President and Chief Operating Officer

Salvatore Russo – Senior Vice President, General Counsel

Christopher Telano – Chief Internal Auditor and Assistant Vice President

Julian John – Corporate Comptroller

Paul Albertson – Vice President, Procurement

* Others may be identified during the course of the audit

Other Considerations

Liquidity

The Auditor's Responsibility under AU-C Section 570, The Auditor's Consideration of an Entity's Ability to Continue as a Going Concern

- The auditor has a responsibility to evaluate whether there is substantial doubt about the entity's ability to continue as a going concern for a reasonable period of time....The auditor's evaluation is based on knowledge of relevant conditions and events that exist at or have occurred prior to the completion of fieldwork.
- The auditor's considerations should be based on knowledge of the entity, its business, and its management, and should include (a) reading of the prospective financial information and the underlying assumptions and (b) comparing prospective financial information in prior periods with actual results and comparing prospective information with the current period results achieved to date.

The following areas are going concern considerations:

- Income (loss) from operations trends
- Working capital trends
- Cash flow trends
- Net deficit position
- Debt covenant compliance

The engagement team will review the March 31, 2016 internal financial statements to preliminarily assess the liquidity of the Corporation

Other Considerations (continued)

Liquidity (continued)

KPMG may request the information about management's plans:

- Fiscal 2017 budgets and cash flow projections
- Written representation from management regarding plans
- Board and Finance Committee meeting minutes
- Transforming Health + Hospitals report (One New York – Healthcare for Our Neighbors)
- Other reports and findings, if applicable

Additionally, KPMG may review:

- Fiscal 2016 budget to actual results (reliability of budgeting process)
- Working capital, operating income (loss) and cash flow from operations (liquidity)
- Continued support from the City of New York

New Accounting Pronouncements

- ***GASB 73, Accounting and Financial Reporting for Pensions and Related Assets that are not Within the Scope of GASB Statement 68, and Amendment to Certain Provisions of GASB Statements 67 and 68***
 - Effective for reporting periods beginning after June 15, 2015
- ***GASB 76, The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments***
 - Effective for reporting periods beginning after June 15, 2015

KPMG resources

KPMG's Audit Committee Institute (ACI)

Established in 1999

- KPMG's commitment to communicating with Audit Committee members and other participants in the financial reporting process
- www.kpmg.com/aci
- Publications of the ACI
 - Audit Committee Insights – www.kpmginsights.com
 - Audit Committee Quarterly – <http://www.kpmg.com/aci/quarterly.htm>
 - Audit Committee Institute Roundtables – www.kpmg.com/aci/roundtables.htm
 - ACI Website: www.kpmg.com/aci
 - ACI mailbox: auditcommittee@kpmg.com | ACI hotline – 1-877-KPMG-ACI
- Healthcare Publications
- KPMG Insiders: Healthcare – www.kpmginsiders.com
- Healthcare Business Briefing



kpmg.com/socialmedia

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**AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS**

**Corporate Compliance Report
June 9, 2016**

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I. Monitoring of Excluded Providers

Overview

- 1) Federal regulations provide that “no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished . . . by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.”¹ New York State regulations also provide that “no payments will be made to, or on behalf of, any person for the medical care, services or supplies furnished by or under the supervision of the person during a period of exclusion” from participation in the Medicaid program.²
- 2) Further, to maintain an active enrollment status in the Medicare program, NYC Health + Hospitals must certify that it does not employ or contract with individuals or entities that are “excluded from participation in any Federal health care programs for the provision of items and services covered under the programs”³
- 3) To adhere to these regulations, each month the Office of Corporate Compliance (“OCC”) confirms that none of the NYC Health + Hospitals (the “System”) System’s workforce members (e.g., employees, board members, affiliates, and medical staff members), vendors, and DSRIP partners are excluded from participation in State or federally funded programs such as Medicaid and Medicare. The performance of these monthly checks are consistent with the recommendations of the NYS Office of the Medicaid Inspector General (“OMIG”)⁴ and the United States Department of Health and

¹ Scope and Effect of Exclusion 42 CFR § 1001.1901 (b); *see also* 42 CFR § 1002 (authority of State agencies to exclude on their own initiative, regardless of whether the OIG has excluded an individual or entity).

² *See* 18 NYCRR 515.5; *see also* 18 NYCRR 515.2(b) (7) (includes employment of and submitting a claim for services rendered by a suspended or disqualified from participation in the program as an unacceptable practice under the medical assistance program and conduct which constitutes fraud or abuse.)

³ *See* 42 CFR § 424.516 (a) (3); *see also* 42 CFR § 424.535(a) (2) (regarding CMS’ option to revoke enrollment and billing privileges due to exclusion from Medicare, Medicaid or any federal program). *See also* 42 USC 1320c-5 (Regarding obligations of health care practitioners and providers and the Secretary of Health and Human Services’ right to exclude a person or entity for failing to meet the obligations.)

⁴ DOH Medicaid Update April 2010, Vol.26, No. 6 and the NY OMIG webinar #22 OMIG Exclusion and Reinstatement Process <https://omig.ny.gov/resources/webinars/811-omig-webinar-22>, Slide 20 (Sept 2014), accessed March 29, 2016.

Human Services Office of the Inspector General (“OIG”)⁵ to ensure compliance with State⁶ and Federal regulations.⁷

Exclusion and Sanction Screening Report for February 2016 through May 2016

4) Since the Office of Corporate Compliance last reported excluded provider activities at the February 2016 Audit Committee, there have been no new verified exclusions to report.

II. Privacy Incidents and Related Reports for the First Quarter of CY 2016 (January 1, 2016 to March 31, 2016)(“First Quarter of CY16”)

Background

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

Reportable Privacy Incidents for the First Quarter of Calendar Year 2016 (January 1, 2016 to March 31, 2016 – hereinafter “1st Quarter of CY16”)

2) During the 1st Quarter of CY16, twenty-seven (27) complaints were entered in the ID Experts RADAR Incident Tracking System. Of the 27 complaints entered in the tracking system ten (10) were found after investigation to be violations of HHC HIPAA Privacy Operating Procedures; five (5) were determined to be unsubstantiated; eight (8) were found not to be a violation of HHC HIPAA Privacy Operating Procedures; and four (4) are still under investigation.

- Of the 10 incidents confirmed as violations, five were determined to be breaches.
- A total of 5 patients were affected by the five confirmed breaches.

⁵ Special Advisory Bulletin titled “Updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs”, May 8, 2013 pg. 6-17, <http://oig.hhs.gov/exclusions/files/sab-05092013.pdf>, accessed March 29, 2016.

⁶ NYS’s Compliance Program Requirements include an obligation to have a “system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to... appropriate ... audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting,...” 18 NYCRR 521.3 (c) (6).

⁷ See Scope and Effect of Exclusion 42 CFR § 1001.1901.

Breach Defined

3) A breach is an impermissible use, access, acquisition or disclosure (hereinafter collectively referred to as “use and/or disclosure”) under the HIPAA Privacy Rule that compromises the security and privacy of PHI maintained by the Corporation or one of its business associates.⁸

4) Pursuant to 45 CFR § 164.402 [2], the unauthorized access, acquisition, use or disclosure of PHI is presumed to be a breach unless the System can demonstrate that there is a low probability that the PHI has been compromised based on the reasonable results of a thorough risk assessment, that is completed in good faith, of several key risk factors.⁹

Factors Considered in Determining Whether a Breach has Occurred

5) Under HIPAA regulations, at a minimum the following four key factors must be considered to determine whether there is greater than a low probability that a privacy and/or security incident involving PHI has resulted in the compromise of such PHI:¹⁰

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

Reportable Breaches in the 1st Quarter of 2016

6) As stated above, there were 5 reportable breaches in the 1st Quarter of 2016. Below is a summary of said breaches:

- Coney Island Hospital – February 2016.

⁸ 45 CFR § 164.402 [“Breach” defined].

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

¹⁰ See 45 CFR § 164.402 [2][i-iv].

Incident: The incident involved a NYC Health + Hospitals nurse-employee who accessed the record of a patient who was also a Health + Hospitals employee. The patient claimed that the nurse-employee accessed the record without authorization. During an investigatory interview of this matter the nurse-employee denied any inappropriate access. However, an access audit report confirmed that the nurse-employee had in fact accessed the record without authorization as the employee was not part of the patient's treatment team.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and breach notification was sent to the affected individual on April 1, 2016.

Mitigation: The employee was suspended pending a Human Resources conference to determine final disciplinary actions.

- Kings County Hospital Center – February 2016.

Incident: The incident involved the unauthorized disclosure of sensitive health information to an attorney working on behalf of the affected patient. The patient completed an Authorization to Disclose Health Information form but did not request that the sensitive information be disclosed. IOD Incorporated is a NYC Health + Hospitals vendor that provides copy service support to Health Information Management departments. The IOD staff at Kings responded to the request for information; however, they provided additional sensitive information not authorized by the patient.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on April 18, 2016.

Mitigation: All IOD staff receive initial formal HIPAA training from both the vendor as well as Kings at the onset of their employment. Disciplinary action was taken against the IOD staff by the vendor. The Kings Facility Privacy Officer also provided HIPAA re-training for the IOD staff.

- Kings County Hospital Center – March 2016.

Incident: The incident occurred when the attorney of a patient received a copy of a medical record belonging to another patient. The patient had requested a copy of their medical record to be sent to the attorney. Upon discovery of the error, the attorney immediately notified the facility. The

error was due to the similarity of the medical record numbers which only differed by one digit.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on May 5, 2016.

Mitigation: The attorney destroyed the documents at the request of the facility. The destruction was confirmed verbally. Disciplinary action included retraining for both the employee and their supervisor in the proper procedures for verifying patient identity utilizing multiple identifiers and maintaining patient privacy.

- Lincoln Medical Center – March 2016.

Incident: The incident occurred when a patient received the written prescriptions intended for another patient. The prescriptions had the correct patient name and medication but were provided to the wrong patient. The patient was seen in the pain management clinic and was provided with the prescriptions by their treating provider. The patient submitted the prescriptions to a pharmacy, whereby the pharmacy noticed that the patient information did not match. The patient returned the prescriptions to the facility and was provided with the correct prescriptions.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on May 16, 2016.

Mitigation: Risk Management was notified, as was the Patient Safety Officer, Executive Director, Chief Medical Director, and the Chief of Service of the department. The treating provider was retrained to ensure that the patient received the correct prescriptions and was counseled on ensuring that proper verification of patient identity was obtained prior to the release of written prescriptions.

- Lincoln Medical Center – March 2016.

Incident: The incident when a patient received the written prescriptions intended for another patient. The prescriptions had the correct patient name and medication but were provided to the wrong patient. The patient was seen in the emergency department and was provided with the prescriptions by their treating provider. The patient submitted the

prescriptions to a pharmacy, whereby the pharmacy noticed that the patient information did not match. The pharmacy notified the facility regarding the error. The patient returned to the facility to receive the correct prescriptions.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on May 13, 2016.

Mitigation: Risk Management was notified as was the Patient Safety Officer, Executive Director, Chief Medical Director, and the Chiefs of Service of the department. The treating provider was retrained to ensure that the patient received the correct prescriptions and was counseled on ensuring that proper verification of patient identity was obtained prior to the release of written prescriptions.

Office of Civil Rights (“OCR”) Inquiries regarding potential and/or determined Privacy Incidents

7) There were no inquiries initiated by OCR in the first quarter of 2016.

III. Compliance Reports for the First Quarter of Calendar Year 2016 (January 1, 2016 to March 31, 2016)(“First Quarter of CY16”)

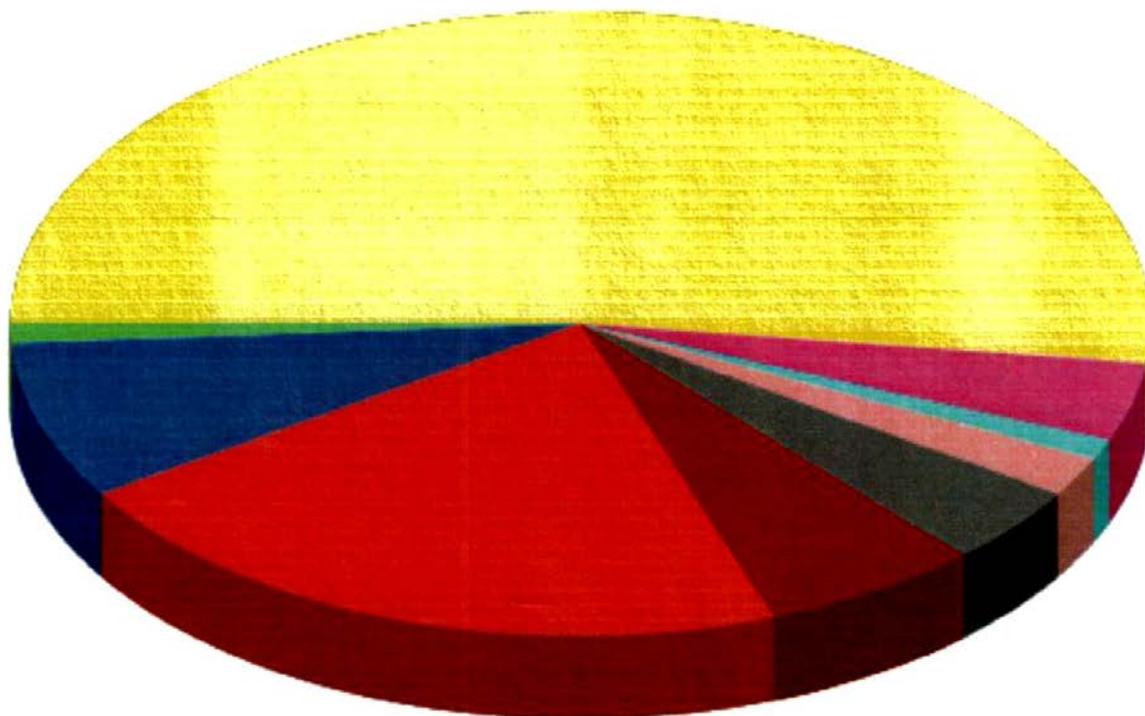
Summary of Reports

1) For the First Quarter of CY2016 there were 98 compliance-based reports of which one (1) (or 1%) was classified as a Priority “A”,¹¹ 30 (or 30.6%) were classified as Priority “B”, and 67 (or 68.4%) were classified as Priority “C” reports. For purposes here, the term “reports” means compliance-based inquiries and compliance-based complaints. Of the 98 reports received during this period, 51 (or 52%) were compliance complaints received on the OCC’s anonymous toll-free compliance hotline.

¹¹ There are three (3) different report categories: (i) Priority “A” reports - matters that require immediate review and/or action due to an allegation of immediate threat to a person, property or environment; (ii) Priority “B” reports – matters of a time-sensitive nature that may require prompt review and/or action; and (iii) Priority “C” reports – matters that do not require immediate action.

Mode of Reporting

Total items in this report: 98

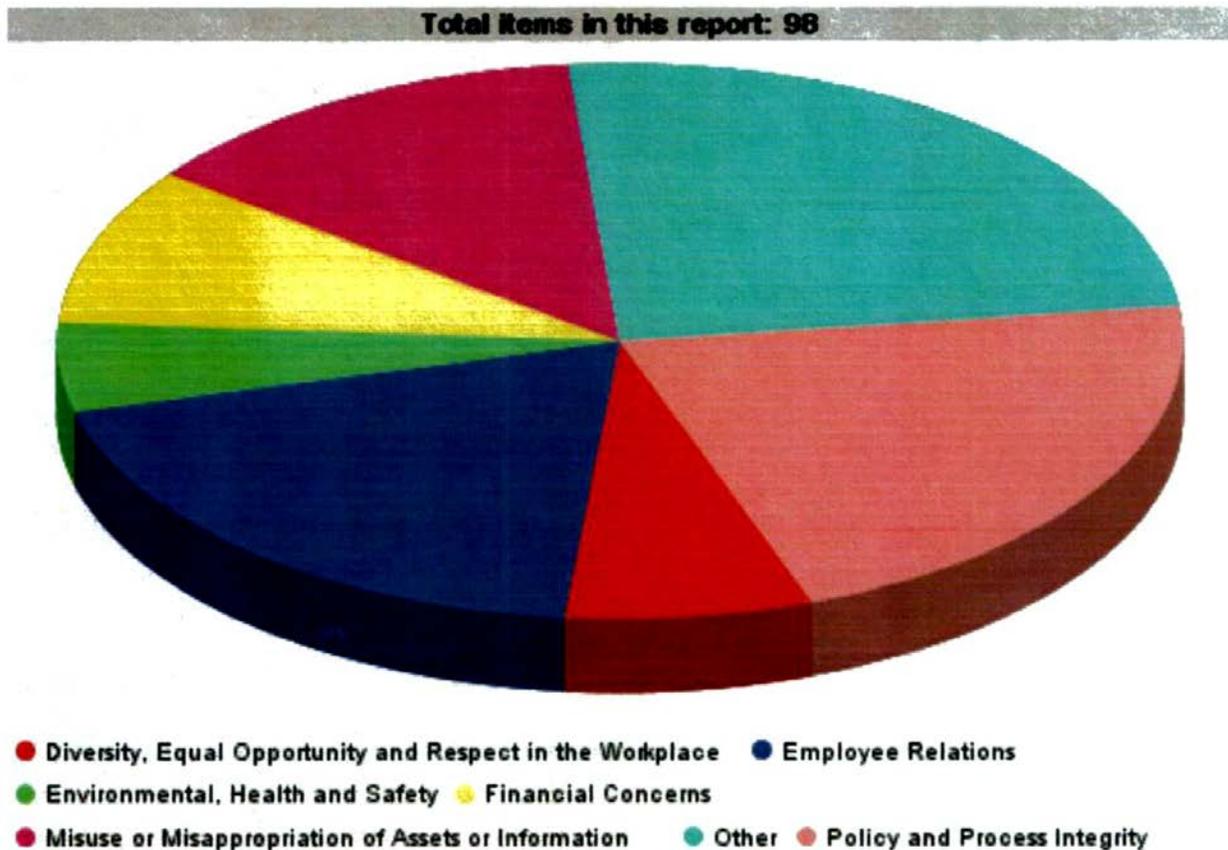


● E-Mail ● Face to Face ● Fraud & Abuse Form (e) ● Hotline ● Mail ● Office Visit ● Other
● Referral from other HHC Office ● Telephone

- 2) Below is a summary of how the OCC received the 98 CY2016 first quarter reports:
- a. 51 (52%) were received on the Help Line;
 - b. 21 (21.4%) were received via E-mail;
 - c. 8 (8.2%) were received via Face-to-Face;
 - d. 6 (6.1%) were received via Telephone;
 - e. 4 (4.1%) were received via Mail;
 - f. 4 (4.1%) was received via Interoffice Mail (referral from other System Office);
 - g. 1 (1%) was received via Office Visit;

- h. 2 (2%) was received via Other Means;
- i. 1 (1%) was received via Web Submission.

Allegation Class Analysis



- 3) The breakdown of the allegation classes of the 98 reports received in the first quarter of CY 2016 is as follows:
- a. 16 (16.3%) Guidance Request;
 - b. 11 (11.2%) Unfair Employment Practices;
 - c. 10 (10.2%) Patient Care;
 - d. 8 (8.2%) Inappropriate Behavior;
 - e. 8 (8.2%) Other;
 - f. 7 (7.1%) Accounting and Auditing Practices;
 - g. 6 (6.1%) Customer Relations;

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- h. 5 (5.1%) Falsification or Destruction of Information;
- i. 4 (4.1%) Harassment – Workplace;
- j. 3 (3.1%) Disclosure of Confidential Health Information – HIPAA;
- k. 3 (3.1%) Quality Control;
- l. 2 (2%) Billing and Coding Issues;
- m. 2 (2%) Discrimination;
- n. 2 (2%) Environment, Health and Safety;
- o. 2 (2%) Fraud or Embezzlement;
- p. 2 (2%) Misuse of Resources;
- q. 2(2%) Substance Abuse;
- r. 1 (1%) Conflicts of Interest – Financial;
- s. 1 (1%) Gifts, Bribes and Kickbacks;
- t. 1 (1%) Quality Control – Medical;
- u. 1(1%) Retaliation or Retribution; and
- v. 1 (1%) Threats and Physical Violence.

IV. Actions Taken in HHC Health & Home Care to Reduce to Risk of Falsification of Records

- 1) HHC Health and Home Care Management has instituted a process that provides an internal control against the forging of patient signatures and falsification of visit reports by home health staff members. The plan also serves as a survey of quality of care and patient satisfaction.
- 2) The process involves calls to a selection of patients' homes within the first week after care has commenced and at least one subsequent call after 30-60 days of service. During these calls the patients will be asked a series of questions to verify the visit took place and to assess their satisfaction with the services provided. If a patient or caregiver denies a visit took place, and management is otherwise unable to verify the visit, the OCC will follow up with an investigation as to the workforce member involved. The OCC will review management's process and report the results later this year.
- 3) In addition, as of mid-May, a telephony visit verification system was put into place to assist with visit verification for home health aides. This system requires that all home health aides call from a patient's home when they arrive. While the telephony system can be manipulated by calling from a cell phone physically close to the patient's home, it

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provides daily data to identify any aides who attempt to visit more than one patient at the same time.

4) Telephony software for visit verification is rarely, if ever, used for visits by professional staff (Nurses, Social Workers and Physical Therapists. Nonetheless, Home Care Management is evaluating the cost, need, and efficacy of doing so.

5) In addition to the controls mentioned above, the time stamp now captured by EPIC, in the patient signature field, provides evidence which can be used to confirm suspicion of a forgery. A patient signature entered outside of the time when a staff member was scheduled to visit a patient produces a red flag for investigation.

V. Compliance Training

Overview:

1) Pursuant to internal training policies, Members of the NYC Health + Hospitals Board of Directors, all healthcare professionals (“HCP”), physicians (PHYS) , and Group 11 employees and designated Group 12 employees (“General Workforce” or “GWF”), must undergo computer-based (or live) compliance training on fraud, waste and abuse and other compliance-related matters and topics.

Compliance Training Status for NYC Health + Hospitals Board of Directors

2) As of June 1, 2016, the compliance training status for the Board of Directors BOD is as follows:

- Members of the BOD: 81% (13/16)
- Designee Members of the BOD: 78% (7/9)
- Total: 80% (20/25)

Compliance Training Status for HCP, PHYS, and GWF

3) As of June 1, 2016, the compliance training completion status is as follows:

- HCP: 90% (16,403/18,156)
- PHYS: 89% (4,707/5,306)
- GWF: 71% (5,128/7,274)

VI. Update on DSRIP/OneCity Health Compliance Activities

DSRIP/OneCity Health Compliance Committee Convened

1) A Meeting of the DSRIP/OneCity Health Compliance Committee (“Compliance Committee”) was held on May 19, 2016. At the meeting, the Compliance Committee was informed that the NYC Health + Hospitals Board adopted the updated Principles of Professional Conduct (“POPC”) in April 2016. The Compliance Committee was further informed that a “Plain Language” Version of the POPC was under development along with a POPC “Frequently Asked Questions (FAQs)” for education and dissemination to workforce members and business partners.

DSRIP Compliance Training

2) The Compliance Committee was informed that the OCC has prepared specific DSRIP compliance training slides for use by NYC Health + Hospitals workforce members and PPS Partners involved in the DSRIP Compliance Program. These slides were developed in pertinent part by the Greater New York Hospital Association in collaboration with its hospital members. A copy of the draft training slides were presented at DSRIP/OneCity Health Compliance Committee for review and comment. The training slides will be disseminated to PPS Partners for use where if said PPS Partners do not have comparable compliance training. The training slides will also be posted on the OneCity Health website where it will be available for use by DSRIP Partners.

DSRIP Compliance Line

3) The current NYC Health + Hospitals anonymous compliance reporting telephone helpline has been expanded to accept DSRIP related calls. Moving forward, the Compliance Committee has recommended that a separate compliance reporting helpline number be utilized for DSRIP-related reports and complaints. The OCC will work with the Offices of Procurement and Legal Affairs to amend its current vendor contract to facilitate a separate DSRIP reporting helpline.

VII. Update HHC ACO, Inc. Compliance Activities

1) CMS granted the HHC ACO, Inc. (the “ACO”) a 3 year extension of participation in the Medicare Shared Savings Program effective January 1, 2016.

2) ACO quality measures for 2016 increased from 33 in CY 2015 to 34 in CY 2016. Results for the CY 2015 quality measures are expected to be reported by CMS in June or July 2016.

- 3) As required by ACO regulations, the ACO Compliance Plan has been reviewed and is in the process of being updated. As part of the update, the development of a HHC ACO, Inc., POPC is underway.
- 4) Corrective action plans to remediate deficiencies in the previously reported HHC ACO, Inc., CY 2014 quality measure results are on track.
- 5) Participating Providers in the HHC ACO, Inc., expanded in CY 2016 to include Community Healthcare Network, a FQHC and the first non-affiliated Participating Providers in the ACO.

VIII. U.S. Department of Justice Yates Memorandum

Overview

1) The Yates memorandum (the “Yates Memo”), issued on September 9, 2015, by Deputy Attorney General of the U.S. Department of Justice Sally Quillian Yates, addresses the subject of individual accountability for corporate wrongdoing.¹² In the Yates Memo, Deputy Attorney General Yates provides that holding individual perpetrators accountable ideally deters future illegal activity, while also incentivizing changes in corporate behavior and holding the right people responsible.¹³

Steps to Aid in Pursuing Wrongdoing

- 2) The Yates Memo proposes six steps to aid in pursuing corporate wrongdoing:
 - corporations must reveal all relevant facts relating to responsible individuals to the Department of Justice (“DOJ”) to be eligible for cooperation credit;
 - corporations are not allowed to decide what information to share with the DOJ.¹⁴
 - In order to receive full cooperation credit, a corporation, at minimum, must include all relevant facts about the responsible individuals.

¹² Yates Memorandum, Department of Justice, Sept 9 2015, *available at* <https://www.justice.gov/dag/file/769036/download>

¹³ *Id* at 1.

¹⁴ *Id* at 3.

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- DOJ attorneys will conduct their own investigation and compare their own findings with the information provided by the corporation.¹⁵
- both criminal and civil investigations should focus on individual wrongdoers as opposed to the corporation itself;
 - brings focus on the individual culprit, as opposed to the corporation itself;¹⁶ and
 - focusing on individuals may reduce corporate misconduct and increase cooperation.¹⁷
- It is expected that criminal and civil attorneys establish an open channel of communication between each other, which will allow the government to better understand each individual case and know the available remedies.¹⁸
- culpable individuals may not be released from their respective liability;
 - DOJ attorneys are prohibited from dismissing charges or providing immunity to individual actors except under extraordinary circumstances or pursuant to departmental policy.¹⁹
- DOJ attorneys must have a clear plan to address each individual case; and
- an individual wrongdoer's ability to pay should not factor into whether suit is brought against that individual.²⁰

Significance of the Yates Memo and Board Oversight Responsibilities

3) The Board should be aware that the Yates memo states that absent extraordinary circumstances, DOJ will generally not release culpable individuals from civil or criminal liability when resolving a matter with a corporation. It is understood that this reflects a change from prior practice, when releases of a corporation's officials, agents

¹⁵ *Id* at 3.

¹⁶ *Id* at 4.

¹⁷ *Supra* note 1 at 4.

¹⁸ *Id* at 5.

¹⁹ *Id* at 5.

²⁰ *Id* at 2-3.

and employees may have been more routinely included in settlement agreements with DOJ.

IX. Development of Written Policies and Procedures related to Compliance Risk Areas

1) The OCC has developed the following written policies and procedures for promulgation System-wide:

- Mandatory Reporting and Overpayments;
- Excluded Provider Screening;
- Overview of the Civil Monetary Penalties Law and the Prohibition of Acts that may lead to the Imposition of Civil Monetary Penalties;
- Prohibition of Acts that Constitute Criminal Health Care Fraud;
- Overview Stark Law and AntiKickback Statute and the Prohibition of Improper Business Arrangements and Referrals; and
- Overview of the False Claims Act and the Prohibition of the Submission of False Claims.

2) The aforementioned policies and procedures are in their final stages of review by outside legal counsel. Except for the operating procedure concerning the Stark Law and AntiKickback Statute, all of the above operating procedures are expected to be in full force and effect by the end of June 2016.

3) It is anticipated that the Stark and AntiKickback operating procedure will be promulgated in late July 2016.

X. Meeting of Gotham Health FQHC, Inc. Board of Directors on April 26, 2016

1) A meeting of the Members of the Gotham Health FQHC, Inc. (“Gotham”) Board of Directors with the Senior Assistant Vice President/Chief Corporate Compliance Officer (“CCO”) of NYC Health + Hospitals was held at Segundo Ruiz Belvis Diagnostic and Treatment Center on April 25, 2016, at 6:00 p.m.

2) Mr. McNulty provided compliance training to the Gotham Board by utilizing a PowerPoint presentation. As part of the compliance training, he distributed to those present in person or by telephone conference at the meeting the following: (i) NYC Health + Hospitals Operating Procedure 50-1 (Corporate Compliance Program) (ii) A copy of the resolution of the Audit Committee of the NYC Health + Hospitals Board of Directors adopting the revised Principles of Professional Conduct (“POPC”), and an executive summary explaining the POPC and a copy of the revised POPC; and (iii) a compliance PowerPoint presentation, which covered the following compliance topics:

- A brief overview of the NYC Health + Hospitals and Gotham Health FQHC co-applicant agreement;
- A general overview of compliance;
- The importance of board member compliance training;
- Governing body fiduciary duty of care and its relation to compliance;
- The eight elements of an effective compliance program under New York State compliance program regulations;
- Definitions of fraud, waste and abuse; and
- Important laws that address fraud, waste and abuse.

3) At the conclusion of the compliance training, Mr. McNulty answered questions posed by the Gotham Board related to compliance, fraud, waste and abuse.

XI. Meeting of Gotham Health FQHC, Inc., Compliance Committee on May 10, 2016

Overview of the Compliance Meeting

1) A meeting of the members of the Compliance Committee of the Gotham BOD convened via telephone conference on May 10, 2016.

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- 2) The Compliance Committee of the Gotham Board discussed the following topics:
- The revised POPC; and
 - The development of written compliance policies and procedures related to compliance risk areas (see subdivision 6 of this section for greater detail).

Gotham BOD Adoption of the POPC

- 3) Mr. McNulty explained to the Gotham Compliance Committee that the NYC Health + Hospitals Board adopted by resolution the updated/revised POPC in April 2016.
- 4) Mr. McNulty reminded the Gotham Compliance Committee that at the April 25, 2016 Gotham Board meeting, the POPC was slated to be presented to the Gotham BOD at their June 2016 meeting for formal adoption by Gotham Board.
- 5) The OCC presented the POPC for consideration and adoption by the Compliance Committee of the Gotham Board as a prerequisite to the full Gotham Board's consideration and adoption of the same. The Gotham Compliance Committee unanimously approved the adoption of the POPC.

Report on Draft Compliance Operating Procedures

- 6) Mr. McNulty reported to the Gotham Compliance Committee that the OCC was in the process of drafting new Compliance Operating Procedures on important topics such as Screening of Excluded Providers, Overpayment Payments and the False Claims Act.

XII. Revised Guide to Compliance at NYC Health + Hospitals

- 1) The OCC has revised the NYC Health + Hospitals Guide to Compliance, which covers fraud, waste and abuse topics, as well as HIPAA policies and procedures.

XIII. Medicare Claims Denials Received from National Governmental Services.

- 1) OCC has reviewed 45 notices of Medicare claims denials received by NYC Health + Hospitals from National Governmental Services ("NGS"), the System's Medicare Administrative Contractor, for calendar year 2015. Each NGS notice describes the reasons for the Medicare claims denials for the NYC Health + Hospitals facility which submitted the claims.

Top Four Reasons For Medicare Claims Denials During the Denial Period.

2) There were 11 reason codes cited in the NGS notices for calendar year 2015. Below are the top four reasons NGS gave for denying Medicare claims for that period.

- *Reason Code U5233 was cited 63 times for calendar year 2015. U5233 codes for when a provider submits a claim to Medicare for a patient who have elected a Medicare Health Maintenance Organization. Of the 63 citations 10 were from Lincoln and 10 were from Jacobi.*
- *Reason Code T5052 was cited 20 time for calendar year 2015. T5052 codes for when there is no Medicare record for the beneficiary on the claim. Of the 20 citations 9 were from Bellevue and 9 were from Jacobi.*
- *Reason Code 38032 was cited 19 times for calendar year 2015. 38032 codes for when there is a duplicate claim of a previously process outpatient claim where the dates of service are the same and at the least one revenue code and one diagnosis code matches the original claim. Of the 19 citations 9 were from Bellevue and 9 were from Coney Island.*
- *Reason Code 38200 was cited 6 times for calendar year 2015. 38200 codes for when a previously submitted billing transaction is found to be a duplicate of a recently submitted billing transaction and where 8 NGS predetermined fields regarding the history and processing of the claim are the same.*

OCC and Revenue Management Remediation Actions.

3) OCC is working with the Office of Revenue Management to arrange a series of educational webinars to be presented to each acute care facility of NYC Health + Hospital by the NGS Medicare Provider Outreach and Education Team. The presentations will focus on the facility specific issues creating the denials at each of the facilities. The facility staff will be able to ask questions and then, after the webinar, the facility staff can create plans to ameliorate the processes at their facility to reduce the number of Medicare Claims denials. The webinars for each of the 11 acute care facilities are currently being scheduled to occur during summer/fall 2016.

4) With regard to duplicate claims, the Office of Revenue Management has inactivated a systems processing logic that was erroneously creating such duplicate claims.