

AUDIT COMMITTEE
MEETING AGENDA

September 11th, 2014

11:00 A.M.

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

CALL TO ORDER

- Adoption of Minutes June 12, 2014

Ms. Emily A. Youssouf

INFORMATION ITEMS

- Audit of Artwork Management Follow-up
- Audits Update
- Compliance Update

Mr. Joe Schick

Mr. Chris A. Telano

Mr. Wayne McNulty

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

New York City
Health and Hospitals Corporation

MINUTES

AUDIT COMMITTEE

MEETING DATE: June 12, 2014

TIME: 11:30 AM

COMMITTEE MEMBERS

Emily A. Youssouf, Chair

Josephine Bolus, RN

STAFF ATTENDEES

Antonio Martin, Executive Vice President/COO

Salvatore J. Russo, Senior Vice President & General Counsel, Legal Affairs

Deborah Cates, Chief of Staff, Chairman's Office

Randall Mark, Chief of Staff, President's Office

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

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

Bert Robles, Senior Assistant Vice President/CIO, EITS

Jay Weinman, Corporate Comptroller

Martin Genee, Deputy Comptroller

James Linhart, Deputy Comptroller

Roslyn Weinstein, Senior Assistant Vice President, Office of Facilities Development

Peter Lynch, Assistant Vice President, Office of Facilities Development

Enrick Ramlakhan, Assistant Vice President, Business Applications

Gloria Velez, Senior Director, Human Resources

John Yan, Senior Director, Corporate Payroll

Nelson Conde, Senior Director, Central Office

Gassenia Guilford, Assistant Vice President, Finance

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

Wayne McNulty, Corporate Compliance Officer

Devon Wilson, Senior Director, Office of Internal Audits

Steve Van Schultz, Director, Office of Internal Audits

Zhanna Kelley, Assistant Director, Office of Internal Audits

Carlotta Duran, Assistant Director, Office of Internal Audits

Delores Rahman, Audit Manager, Office of Internal Audits

Frank Zanghi, Audit Manager, Office of Internal Audits

George Asadoorian, Senior Auditor, Office of Internal Audits

Jonathan Delgado, Senior Auditor, Office of Internal Audits

Cynthia McIntosh, Senior Auditor, Office of Internal Audits

Roger Novoa, Senior Auditor, Office of Internal Audits

Armel Sejour, Senior Auditor, Office of Internal Audits

Rosemarie Thomas, Senior Auditor, Office of Internal Audits

Jean Saint-Preux, Staff Auditor, Office of Internal Audits

Barbarah Gelin, Staff Auditor, Office of Internal Audits

Satish Malla, Staff Auditor, Office of Internal Audits

Gillian Smith, Staff Auditor, Office of Internal Audits

Guzal Contrera, Staff Auditor, Office of Internal Audits

Dean Mihaltses, Associate Executive Director, Elmhurst Hospital Center

Edie Coleman, Senior Associate Director, Metropolitan Hospital Center

Anthony Saul, Senior Associate Director, KCHC/DSSM/ENY

Ronald Townes, Associate Director, Finance, Kings County Hospital Center

OTHER ATTENDEES

KPMG: Maria Tiso, Partner, Joseph Bukzin, Senior Manager

OMG: Kristin Raffaely, Analyst

JUNE 12, 2014
AUDIT COMMITTEE OF THE BOARD OF DIRECTORS
NYC HEALTH & HOSPITALS CORPORATION

A meeting of the Audit Committee was held on Thursday, June 12, 2014. The meeting was called to order at 11:32 AM by Ms. Emily A. Youssouf, Committee Chair. Ms. Youssouf asked for a motion to adopt the minutes of the Audit Committee meeting held on April 13, 2014 and of the Special Audit Committee meeting held on May 22, 2014. A motion was made and seconded with all in favor to adopt both sets of minutes. An additional motion was made and seconded to hold an Executive Session of the Audit Committee.

Ms. Youssouf then stated that there are two action items on the agenda. For the first one she turned the floor over to Mr. Wayne McNulty.

Mr. McNulty introduced himself as the Senior Assistant Vice President and Corporate Chief Compliance Officer. He then moved forward by introducing the resolution to adopt, pursuant to the Arts and Cultural Affairs Law Section 57.25 [2], the Records Retention and Disposition Schedule MI-1, which was promulgated by the Commissioner of the Department of Education in 1998 and revised in 2006. He stated that 8 NYCRR § 185.14 and 8 NYCRR Appendix K, pursuant to § 57.25[2] of Article 57 of the Arts and Cultural Affairs Law - - which is also known as the Local Government Records Law, provides that no officer of a public-benefit corporation may destroy or otherwise dispose of a record, as that term is defined the Arts and Cultural Affairs Law § 57.17[4], without the consent of the Commissioner of the New York State Department of Education (the "Commissioner"). He stated that HHC was a public-benefit corporation created under the State of New York and therefore was a covered entity under the Local Government Records Law pursuant to Arts and Cultural Affairs Law § 57.25[2]. He advised the Audit Committee of the HHC Board of Directors (the "Committee") that the Commissioner had formally consented to the disposition of records held by local government public-benefit corporations provided that: (i) the Disposition Schedule MI-1 found at 8 NYCRR § 185.14 and 8 NYCRR Appendix K was followed; and (ii) pursuant to the Cultural Arts and Affairs Law 57.25[2] and 8 NYCRR §§ 185.4[b] and 185[a][2], HHC's governing body formally adopts by resolution Records Retention and Disposition Schedule MI-1. He advised that the Office of Corporate Compliance ("OCC") and the Office of Legal Affairs ("OLA") reviewed Schedule MI-1 and determined that the following categories or records contained therein apply to HHC.

The general categories: archives and records management, attorney or counsel, building and property regulations, disaster preparedness, electric, gas and utility, electronic-data processing, energy, environmental health, executive, manager or administrator, fiscal, human rights, economic opportunity, insurance, miscellaneous, personal, civil service, public access to records, public employment and training, public health, public property and equipment, public safety, recreation and taxation assessment.

There being no further discussion on this item, the Committee approved the resolution for the full Board's consideration.

Mr. McNulty introduced the next resolution which was the designation of William Gurin, Deputy Corporate Compliance Officer, OCC, as the Records Management Officer of the Corporation, as that term is defined in the New York State Education Department Regulations found at 8 NYCRR § 185.1[a], to coordinate the development of and oversee HHC's record-management program in accordance with the requirements set forth under Article 57-A.

Ms. Youssouf asked Mr. Gurin to introduce himself and to briefly summarize his background.

Mr. Gurin introduced himself and stated that he has more than forty years of experience in law enforcement. He stated that he was with the United States' ("U.S.") Attorney Office, Eastern District of New York, for 16 years. He informed

the Committee that he was with the Kings County District Attorney's Office and was Chief of their Economic Crimes and Arson Bureau for a period of more than 13 years. He added that, at the U.S. Attorney's Office, he was the Deputy Chief in the General Crimes Division in addition to being the Assistant U.S. Attorney in the Organized Crime and White Collar Division. He informed the Committee that he worked for the New York State Attorney General's Office for about four years. He further provided that he worked as the Inspector General for the New York State Workers' Compensation Board, where he was involved in regulatory enforcement and fraud investigations. Ms. Youssouf stated that his background was very impressive and welcomed him. She then asked if there were any questions. There being none, she asked for motion to approve. The resolution was approved for consideration by the full Board.

Ms. Youssouf then moved on to the information items.

Mr. Jay Weinman introduced himself as the Corporate Comptroller and Mr. Martin Genee, Deputy Corporate Comptroller. As a result of an audit, there were some findings related to the Social Security numbers, specifically on the reports used by the Finance Department. We also found a couple of other reports and took the liberty to change the payroll register to eliminate social security numbers. Even though it was not referenced within the report, there was some mention of a payroll register and have fixed that as well. As of the last pay period, the Social Security numbers have been removed. In addition, the paycheck stubs also contained social security numbers and those were also removed. As for the actual grants report that is being used and widely known throughout the Corporation as the PARM report, it is a payroll report. It does contain social security numbers, but it is a report that is used within the Payroll Department for W-2s and therefore requires the social security numbers so that the employees can look up individuals based on the federal tax identification numbers. We have begun to identify those employees that are not part of the Payroll Department or in HR and will be removing their access from that report entirely. We are working with IT so that we could adjust further for the Payroll Department to have limited access, but we have to go through each and every one of the users and assess whether they actually need it. For now, we know that Payroll needs it, so we are going to review the access for Payroll employees until we actually identify every employee and their need to access this information.

Ms. Youssouf asked how many people are currently in the Payroll Department. Mr. Genee said that it varies – obviously we have a number of facilities, and could run from two to maybe seven per facility. They are probably at least a hundred staff in Payroll across the Corporation. Ms. Youssouf asked if there have been any breaches. To which Mr. Genee responded no.

Ms. Youssouf asked if IT believes that they can manage this additional task. Mr. Ramlakhan from Business Applications responded yes, that they are comfortable they can work with the Weinman's team.

Ms. Youssouf stated that she was glad that they addressed it so quickly and came to a solution that is fairly easy to do and that will continue to protect everyone's personal information. She then asked Mrs. Bolus if she had any questions.

Mrs. Bolus asked how long they will keep those records. Mr. Ramlakhan said that they do not destroy those records.

Mrs. Bolus then asked if they used up all the ones they had before. To which Mr. Weinman responded that the payroll reports that were being used particularly by grants were used to support the amounts claimed on the grants, and when they used the reports, they blacked out the social security numbers; but the report did exist. We wanted to limit the existence of the reports all together so it does not contain social security numbers, but there may have been some out there. We do not know the extent that a hospital may have had them, but going forward they will not have those and any previous reports, electronic or hardcopy, are being secured.

Ms. Youssef asked where the paper from the prior years is. Mr. Weinman answered that he did not know. We have to assess that, we have the reports that come from the grants department, but they may have other copies.

Ms. Youssef said that the only remaining vulnerability is that every facility seems to have its own storage area.

Mr. McNulty said that most of the facilities do have an appropriate storage area and so long as the documents are kept securely and the record-retention schedule has not expired. Then it is appropriate to keep the documents whether they are kept onsite or within appropriate storage facilities offsite.

Mr. Martin stated that his concern is that there may be other departments where there may be the same exposure, and Chris Telano will be looking at that to assure corporate-wide that we do not have this type of exposure in other departments.

Mr. Telano said he already met with Mr. Ramlakhan last week in regard to this matter and have a meeting with Human Resources next week to address it again.

Mrs. Bolus asked if the record retention order would include records of ten or fifteen years ago with social security numbers. Mr. McNulty responded that depending if the social security number is part of a file and that file under the records-distribution schedule calls for keeping the records for 15 years. The records do not have to be kept for that period of time, given that this is sensitive information, then that social security number, unless it serves some other legal, fiscal or administrative purpose that the facility then that record should also have been destroyed.

Mrs. Bolus asked if it's retroactive. To which Mr. McNulty answered that it is retroactive. Even when they revised the schedule in 2006, the majority of the schedule stays intact from 1988.

Mr. McNulty stated that the Office of Corporate Compliance is working with the various networks to reduce the number of records unnecessarily stored at the City Storage and any other offsite facility. He has begun to work with Queens Health Network and the North Bronx Health Network, and in fact Jacobi Medical Center just submitted a request to destroy ten thousand records. His goal is to reduce the amount now, which is four million dollars a year for City Storage to get that down to two million by next year.

Mrs. Bolus stated that HHC pays a lot for storage. We have a lot of facilities that are being downsized and whole buildings are just sitting there with nothing. Is it possible to use them for storage? To which Mr. Martin responded that yes, we can look at that, but one of things particularly when you are considering storing records is the weight on the floor because the paper records are very heavy. That is why medical records department and file charts are usually in the basement or first floor because the weighting of the floor has to be able to sustain the weight.

Mr. McNulty added that humidity control, temperature control. There are a number of environmental factors that the Commissioner of Education mandates in place when you store records.

Ms. Youssef said that it is a big task and she is glad it is addressed because it is something that could obviously hurt a lot people in the wrong hands. She thanked them and moved on to KPMG to discuss the 2015 audit plan.

Ms. Maria Tiso introduced herself as the new engagement partner rotating on taking over for Mr. Jim Martell for the 2015 audit going forward and she introduced Mr. Joe Bukzin as the new senior manager on the account responsible for coordinating and monitoring and dealing with management on the day-to-day activities of the Corporation. He

comes to the team with a significant amount of healthcare experience and assists with the accounts. Many of the items in the 2015 audit plan presentation have probably been seen before so we will not go through everything. Once again we will utilize BCA Watson Rice as the minority business enterprise and we changed the women's business enterprise, we will utilize Healthcare Management Solutions staff. They have significant expertise working in the reimbursement area.

Ms. Tiso began the presentation by stating that they will utilize as in the past subject-matter professionals in areas that require significant audit judgments such as tax, pension, facility compliance, reimbursement, and IT. Those team members will be incorporated as part of the audit, and then other partners, Mr. Jim Martell will be available to us as a healthcare resource. There is always another partner that reviews the set of financial statements when they are done to make sure nothing was missed. We have assembled a significant team and spent a lot of time making sure we have an A-team serving the Corporation. Pages three and four are the KPMG deliverables that we will be issuing. These are consistent with what was listed in the RFP, consistent to what we have issued in the past except for one deliverable on the first page, the HHC ACO. During the year, we need to work with management to identify if it is going to be significant enough to warrant issuance of financial statements.

Page five, objectives of an audit, obviously it is for KPMG to issue an opinion on the financial statements of the Corporation and to make sure that they are reasonably stated. Pages six, management's responsibility – it is very important to make sure that internal controls are working effectively, making sure that HHC complies with the existing laws and regulations. Making sure financial records and information is available to the auditors and making sure that the financial statements are correct. Page seven, Audit Committee's responsibility is one of oversight and monitoring. The Audit Committee does rely on auditors, the internal auditors and management as it relates to the fair presentation of the financial statements. KPMG's responsibility is to make sure the financial statements are appropriate and material, making sure that we comply with all of the professional standards.

Ms. Tiso then turned the presentation over to Mr. Joe Bukzin, to walk through an audit timeline. Ms. Tiso recalled the meeting with Jay Weinman that occurred two weeks ago to discuss significant items that needs to be addressed during the year. This has been incorporated as part of the audit plan and as things change, Mr. Weinman will inform the audit team and plan changes will be made as needed.

Mr. Bukzin saluted the Committee and asked to turn to page eight, which is where we start going through the financial statement audit timetable. It runs over the course of three pages and at a quick high level you can see significant time is spent on the HHC audit during the year. It coincides with KPMG's audit process, April through June, this is really the planned process of the audit, meeting with management as well as meeting internally to determine the audit approach and the audit strategy for all deliverables. During June through July is KPMG control-evaluation phase. This is when specific sites are visited, testing certain controls are conducted and also incorporating some elements in the audit are done. On page nine, the August through September phase, this is the nuts and bolts of the audit. This is when we are really digging through and going through our substantive audit procedures, forming our conclusions, addressing any matters of management and ultimately finalizing and issuing financial statements. Some ancillary items subsequently follow, in October the debt covenant compliance letter is issued and in November the final management letter to the Audit Committee is presented.

Ms. Youssof stated that regarding the final management letters, it seems that we are going back to what it was a couple of years ago and we have been doing so well about getting it sooner. So I do not think this is acceptable – it's has to come sooner.

Mr. Bukzin responded that there may have been a draft as mentioned earlier, but it does say that we plan to have draft available in the August-September time line and asked if that was acceptable. To which Ms. Youssouf answered yes, if you add that in. Mr. Bukzin pointed out that page nine of the report indicates the draft is due August-September.

Mr. Bukzin continued by stating that we are already starting to work with management on revisiting the status of prior-year companies as well. For December and February through March, this is MetroPlus time in terms of interim and year-end fieldwork, and then May through July, this is the whole host of regulatory reports, cost reports, charity affairs as well as the insurance company audit. Page eleven highlights certain audit matters; we have categorized these matters into different buckets. The critical audit areas, these are areas that typically involve some level of management judgment and estimation, for example, the evaluation of patient accounts receivable. We will look at management's process, which is typically the result of past history collections and how that impacts current evaluations, so we will continue to look at that and use our computer-assisted audits as we have done in the past. Also, post-employment benefit obligations and OPEB, that is an actuarially-determined item, we will have one of the subject-matter professionals involved in that.

The other audit areas are part of the audit that do not fall into the category of critical but do merit attention as part of our audit process. As another example, patient accounts receivable, different assertions being addressed under this bucket of other audit areas in terms of reviewing, existence and accuracy. We may also inspect the medical records and verify physicians' orders as well. Based on the preliminary discussions with Mr. Weinman and his team we did highlight a handful of non-routine transactions for the Committee to be aware of as part of the audit process and we involve certain professionals to assist us in reviewing the IT general controls, user access, things of that nature.

Page twelve summarizes how we plan to utilize the minority business enterprise, the women's business enterprise and internal audit. The other areas are fairly consistent with the prior year in how we plan to have the internal audit and minority business assist us during this year's audit.

Ms. Youssouf asked Mr. Telano if this is something he has looked at and signed off with his team. Mr. Telano responded that they have discussed this in prior years – we have not met yet, but this is in line.

Mr. Bukzin continued with page thirteen, which covers how we consider fraud in the financial statement audit. We are not opining on fraud in the financial statement audit, but we do need to consider it as part of the audit process. We do that through various meetings with management, evaluating broad controls. Page fourteen highlights some of the individuals we plan to interview and meet during the process. Pages fifteen and sixteen, deal with our responsibility in terms of assessing going concern and liquidity. It is not just an auditor's responsibility; it is also management's responsibility as well to consider the ongoing nature of the organization.

Mr. Martin informed the audit team that the Corporation's procurement processes are now centralized and asked to have Mr. Paul Albertson, Procurement Officer added to the list of people being interviewed. The team members indicated they would do so.

Mr. Bukzin continued with page seventeen which highlights certain new accounting pronouncements as well as a couple that are in the horizon. We will not go in great detail at this point; we are still working on assessing the impact of these pronouncements on the organization. I will however, highlight the pension plans – this is something the City plans on adopting, so that we know will certainly impact the organization. It is my understanding that Mr. Weinman has some plans to meet with the City's actuaries and review how this will impact the organization.

Ms. Youssef asked if the other ones are not as significant. To which Mr. Bukzin answered that based on preliminary review, there is a small piece that talks about assets that are reported and whether they should be talked about, different financing costs as an example, so the organization does have some bond-issuance costs that were recorded and that historically have been amortized over the course of time and the guidance is really saying it should not be.

Mr. Weinman added that we do have some amortized expenses, but they may have to be reported as an expense item. It is not material but the new GASB establishes new categories under the assets and liabilities. Now it will be assets, deferred inflows, liabilities and deferred outflows. The new guideline impacts that and there will be a slight change to the reporting.

Ms. Youssef asked if they have to restate for any of these changes. Mr. Bukzin said that it talks about retrospective application but it would not be a restatement.

Ms. Tiso added that we would have to adjust prior years, but the one that we looked at would be a more significant change than the financial statements because what they are talking about is that all employers regardless that there is a multi-employer plan will have to show on your balance sheet, your net pension liability as well as your expense. There is going to be a whole host of disclosures in the financial statements. This already happened in the world, so it trickles down to GASB years later. We spoke with the City of New York and they are probably going to adopt it, we are going to work hand-in-hand with their actuaries and our actuaries.

Ms. Zurack stated that something similar happened 30 years ago, we had to amortize a major pension restatement. What they are really saying is we are disclosing our share of the pension liability, but they are saying now that even though New York City has fully-funded pension, in this new methodology there may be a different way to view that and there may be some portion that might be considered unfunded, and we are going to have to disclose that and that is something that the City, the Pension Boards are going to have to calculate with the actuary.

Ms. Youssef asked what would that portion be, how do they describe it. To which Ms. Tiso answered that they would have to go back to the literature and compare it to what you have disclosed already to see what the change would be. You do have pieces of it disclosed already, so it may not be that significant.

Mr. Bukzin stated that it does specifically address different types of plan structures. The organization does have a multiple-employer plan, so the guidance does address what you need to accomplish in adopting and implementing that. It talks about cost-sharing plan versus an agent's multiple-employer plan, and that deals with how the investments are pooled and how it is tracked and monitored in terms of whether it is clearly identifiable, would HHC's plan be paying out other employers or is it just HHC.

Ms. Youssef asked Ms. Zurack from her perspective, is it just more detailed. Ms. Zurack said that it means our financial performance in Fiscal '14 is going to take a beating for this because it is a once-in-a-20 year change in methodology. It does not change the cash flow and does not change the pay, but it will add an additional liability, and nobody has any sense of how much. We called the actuary and they had no idea how much it was going to be.

Mr. Bukzin said that he thinks it is the net liability as well, if you have assets set aside and it is also a projected benefit obligation, it would be the net of those numbers.

Ms. Youssef asked what would be the difference from the current balance sheet.

Mr. Weinman stated that currently we have no liability for pension because we pay what our liability is and therefore there is nothing on the balance sheet. These new requirements may have us report certain pieces of the assets and liabilities and have this unfunded liability actually being reported. Right now we have none, and that is dependent on the interest rates and what they feel is at the present moment what is on the balance sheet.

Ms. Zurack said that the New York City Pension Fund decides who could be the greatest return they are going to get on their assets, 7% at this point. This methodology makes you true up; explain in some real earnings, which it may make an additional liability for booking purposes.

Ms. Tiso said that the other significant piece is the disclosure of all of the information, which we will be working with management on that.

Mrs. Bolus asked if we have a lot of union contracts left over to deal with. To which Ms. Zurack stated that we are going to be looking for those contracts and hopefully by September we will have a lot more information – a lot is happening.

Ms. Tiso stated that this concludes their presentation.

Ms. Youssouf turned the meeting over to Mr. Telano for an audit update.

Mr. Telano saluted the Committee and stated that he will go right to pages three, four and five in the briefing, which summarizes the four audits being performed by the New York City Office of the Comptroller. On page three the first one is the Emergency Room Wait Time. That audit began in April 2013, and we just received the preliminary draft report on May 12th of 2014. The draft report only had one finding --there was insufficient evidence that the hospitals evaluated their efforts to reduce ED wait time. HHC decided not to have an exit conference to discuss that lone issue and we expect a final draft report to be issued shortly. On page four is the Navigator audit – there is still no activity since September 2013. That audit began in July 2013 and we have not heard from them in nine months. On the bottom of page four the audit of the affiliation agreement with PAGNY at Lincoln Medical and Mental Health Center -- that audit began on July 19, 2013 and it is still ongoing. They are still gathering information and meeting with staff to document processes. It is the same on page five the Review of Patient Revenue and Accounts Receivable. That audit started in October 2013 and it is still ongoing – they are just gathering information at this point also.

Mr. Telano continued with page six – completed audits. This audit was Work Orders at Elmhurst Hospital Center and he asked the representatives to come up to the table. They approached and introduced themselves as follows: Peter Lynch from Office of Facilities Development (OFD); Dean Mihaltses, Associate Executive Director, Elmhurst I and Roslyn Weinstein, Senior Assistant Vice President.

Mr. Telano said that he will go through the three issues first and then you can address them. The first issue was that we found inconsistent recordkeeping and documentation for construction projects primarily due to the Construction Procedures Manual not reflecting current practices. For example, procedures were not addressed for small-scale projects, and as a result we did not see detailed scope of work, estimates, sketches, drawings and schedules, but if they did include all those documents, it would delay these projects tremendously. In essence, the manual needs to be updated to reflect these small-scale projects.

The second issue involves in some instances there is a lack of communication between construction management at the facility and OFD. For example, during our audit it was noted that there was no evidence of approval of subcontractors hired during the projects. OFD was of the opinion that the facility project manager would assure that

the subcontractor approvals were submitted and the facility believed that the subcontractors were approved and logged in at OFD.

The last issue is regarding the eGordian construction procurement system that is used throughout the Corporation and that there is no central administrator of the system. We recommended that OFD become that administrator so they can start to monitor who has access and as what is going with that system.

Mr. Lynch responded that after the audit, Elmhurst and OFD responded separately, and then we got together, met several times to see what we could do to improve. Clearly, there had been a communications issue. We implemented that OFD and the facilities' managers would meet on a regular basis to strengthen the agenda and begin training to try and improve the process. At July's meeting, we will have the Comptroller's office coming in to do a presentation on prevailing wages and we will keep working in this direction. We will assemble a workgroup and we will work to make the revisions in the policies and procedures so that what we align with the eGordian system and we are working with the modern protocol.

Ms. Youssef asked if they will notify the Committee of any procedural changes. To which Mr. Mihaltzes responded that they will develop this new set of policy and procedures that will reflect what is appropriate and bring it back to the Committee in six months with these changes.

Ms. Youssef asked Mr. Lynch that as she understands it, there is no dollar appointment on a small project, and some of them could be small like \$5,000 or \$10,000. Mr. Mihaltzes agreed and, that they are going to look at both the cost point and also the scope of work. Ms. Youssef then said that while we are very cost conscious obviously, especially about big projects, these small ones that need to be taken care of quickly at a facility, there has to be a way that they do not get held up.

Mrs. Bolus asked if they are aware of how many policies need to be updated and are they on the system yet. Are they still on paper or are they in the computer? To which Mr. Lynch answered that we have an existing policy and we are really going to start at the beginning and work our way through it.

Mrs. Bolus asked if every department has been notified that they should look at all their policies and bring them up to date. Mr. Lynch said that this is just with regard to our construction projects.

Mrs. Bolus added that generally the whole hospital may have problems. Mr. Martin stated that he will assure that we take a look broadly at all of our policies and procedures.

Ms. Youssef asked if OFD knows what is going on at the various facilities, do you feel that you got that under control now. Ms. Weinstein responded that there can always be improvement and part of our new plan as we go through facilities' management and look at construction and also as we look at how we work JCI because there is a very close link between the facilities and Central Office and there is a lot of areas that we see can improve. Part of the facility-managers meeting is to improve that communication.

Ms. Youssef asked if someone has been selected for the eGordian work. Ms. Weinstein said that that is something they will be discussing. Mr. Lynch added that it has to be someone within OFD.

Ms. Youssef added that they look forward to hearing about all your hard work and thanked them.

Mr. Telano continued with his presentation and said that on page seven of the briefing; it is the IT audit of the PeopleSoft application and asked for the representatives to approach the table. They did and introduced themselves as follows: Enrick Ramlakhan, Assistant Vice President, Business Applications and Gloria Velez, Senior Director, Human Resources.

Mr. Telano said that he is happy to report that this audit was a good audit. Overall PeopleSoft is a very efficiently run system, adequate controls in monitoring application design and interfaces and updates. We also looked at the financial aspects of PeopleSoft and we found that payments related to software purchased and ongoing user license agreements all appear to be proper. We found one minor issue related to controlling access to PeopleSoft for consultants and temporary employees, but I believed that has been addressed.

Ms. Velez added that yes, it is and one of the issues that came up is we have consultants and we have some who have hands on in the system, and because they are not employees and they are not in PeopleSoft, there is no way for us to know when they are not working for us anymore. Human resources contacted all those areas that had individuals that had role access to the system to verify that they were still here and that they still needed the access because we rent access. We met with HR directors to remind them that they need to let us know to take away the access. To enforce that I put into place that every two weeks we are looking at the list of individuals that are not employees that have access.

Ms. Youssouf added that that sounds like a great solution, and asked Mr. Bert Robles to stand up and if he was pleased with the outcome. Mr. Robles credited the staff, in particular the team and the advice received over the time spent with the PeopleSoft application audit. The improvements are evident and he expressed his delight in the outcome of the report.

Mr. Telano said that on page eight of the briefing is the listing of the audits in progress and page nine is the progress status of follow-up audits, which are up to date on that and said that that concludes his presentation.

Ms. Youssouf said great and turned the meeting back to Mr. McNulty for the Compliance report.

Mr. McNulty saluted the Committee once again and started with item I-a on page three of the Corporate Compliance Report (the "Report") - the revision of HHC's record management operating procedures. Mr. McNulty informed the Committee that Schedule MI-1, which was adopted by the Committee at the start of the meeting, would be included as an attachment to the new HHC Operating Procedure ("OP") 120-19 - - Guidelines for Corporate Record Retention and Disposal. He explained that the new OP 120-19 would implement Schedule MI-1.

Mr. McNulty continued by highlighting some of the key points of OP 120-19. He provided that the subject OP calls for the reestablishment of a Records Retention Counsel ("RRC"), which will be co-chaired by Mr. McNulty and Mr. Bert Robles, HHC's Senior Vice President & Chief Information Officer. He stated that the RRC was implemented to issue and enforce rules with regard to the subject OP, and to recommend to HHC's President changes to the OP. He explained that 45 days after the end of the fiscal year, the RRC would prepare a report that: (i) documents the total number of records stored by the Corporation; (ii) the current cost of record storage; and (iii) initiatives taken the RRC to show compliance with this procedure. Mr. McNulty said that he would be sharing this report with the Audit Committee in September.

Mr. McNulty explained to the Committee that one of the key points of the resolution that adopted Schedule MI-1 was that no records of significant value will be disposed of. He further explained that, although the record-retention period, for example, for particular record may call for its disposal in six years, if the record is considered an archival record as

designated by the RRC, then such record must be kept for a longer period of time. He elaborated that this was a regulatory requirement because archival records are records required to meet the fiscal, legal or administrative needs of the Corporation or records that contain historically-significant information. He informed the Committee that any HHC record created before 1910 must be kept indefinitely. Mr. McNulty added that some of the records that Jacobi Medical Center requested for destruction were from 1930s and 1940s. He stated those records would be disposed.

Mr. McNulty moved along to page six, paragraphs six and seven. He called to the attention of the Committee that records damaged by disaster, whether manmade or natural, may only be disposed of if the period of retention has been met or approval for their destruction from Commissioner has been secured. He informed the Committee that records at one HHC facility were destroyed during Hurricane Sandy. He added that permission was being sought from the Commissioner to dispose of these records. He added that the records were being evaluated to see if they could be restored. He commented that, for most of the records in question, restoration was not an option.

Ms. Youssouf asked if we have ever asked permission to destroy anything else, and how is it going to take? Mr. McNulty answered no and said that he spoke to the Department of Education; they assured him that it does not take a long time in regard to destruction requests.

Mr. McNulty moved onto subdivision Roman numeral VII of the Report. He advised the Committee that contracts for the use of offsite storage facilities required Department of Education approval. He underscored that the new OP provides a procedure for offsite storage of records which included OLA's approval and, where storage involved electronic records, Information Technology approval.

Mr. McNulty continued by advising the Committee that the subject OP calls for the destruction of inactive records unless an exception exists such as archival records or records that the records retention period requires to be furthered because of clinical, legal, operational, financial, research or other special values.

Mrs. Bolus asked that if we had records dated back to 1930. Mr. McNulty answered yes.

Mrs. Bolus then added that such records were historical with ancestry and asked how you destroy them. Mr. McNulty responded that with regard to the records at the facilities themselves, one of the questions he asked Jacobi was if an assessment was performed to ascertain whether records submitted for destruction had historical, operational, clinical or other value. He explained that in the new OP only a corporate officer could approve the destruction of records and they have to acknowledge that the records do not have any value. He stated, however, that if the RRC has designated a particular series of records as archival, then that choice is not up to the facility. Rather, he further explained, such a designation is corporate policy and those records must be maintained because the RRC has determined that those records have historical value or other significant value.

Mrs. Bolus stated that unless a person knows that their family went there, do you let the community know that there might be some record of their family back in 1930 before it is destroyed. Mr. McNulty said that we have not considered that with regard to the OP but he would share the same with the RRC.

Ms. Zurack asked if there are any records that go forever in terms of retention, like medical records. Mr. McNulty responded no. Mr. McNulty stated that medical records vary based on what facility a given patient was treated at. He explained that if a patient was treated at a mental-hygiene facility then certain records would require a 15-20 year retention. He further explained that medical records pertaining to patients at an Article 28 facility - - a general hospital, generally have to be kept for different periods of time under the Department of Education regulations, Department of Health regulations, and Centers for Medicare and Medicaid Services ("CMS") regulations. He further explained that,

as matter of policy, the record-retention period that will cover all three of those regulations - - which is generally six years if it is an adult patient, if it is a minor 18 years plus three years after that to turn 21, was adopted. However, he elaborated, due to the False Claims Act, both federal and state, all patient records have to be kept a minimum of ten years to be in accordance with the False Claims Act because such records are used basically to support coding and billing.

Ms. Zurack asked what records we have from 1920 and 1930. Mr. McNulty replied that the subject records were patient records that were kept longer than necessary. Mr. McNulty, however, then elaborated that some of the subject records pertain to active patients and it was after they passed away that those records met the period of retention. Mr. McNulty added that some of the subject records were appropriately kept. He explained that if a given patient keeps visiting a facility, the physician is likely to go back with regard to those records. He cited this as an example of a record that may be kept for 50 years, holding that a determination had been made from a clinical-value standpoint that such records should be kept.

Mr. McNulty continued to page eight of the Report – the designation/assignment of the HHC HIPAA Privacy Officer and Security Officer. Mr. McNulty advised the Committee that under the federal HIPAA regulations, HHC was required to designate a HIPAA Privacy and Security Officer. He reminded the Committee that he had served as acting HIPAA Privacy and Security Officer for the past five or six months. He continued by formally and publicly announcing the selection of William Gurin, who would also be serving as HHC’s Record Management Officer, as HIPAA Privacy and Security Officer. He explained that Mr. Gurin would be responsible for; (i) developing and implementing HHC’s HIPAA security policies and procedures; (ii) managing and supervising security measures to protect data related to HIPAA; (iii) developing and implementing HHC’s HIPAA privacy policies and procedures; and (iv) receiving privacy complaints from members of the Corporation or patient population. Mr. McNulty then asked if there were any questions with regard to Mr. William Gurin’s designation.

Mr. Martin asked if Mr. Gurin will be meeting with the representatives from the facilities to make sure that they are knowledgeable and educated on the revised policies and procedures. To which Mr. McNulty responded absolutely. Mr. McNulty stated that each facility has a privacy officer that will have a dotted line to Mr. Gurin. He added that facilities also have facility security officers who meet regularly.

Mr. McNulty continued to page nine – the privacy reports. He informed the Committee that in April there was a loss of a parcel mailed by the U.S. Postal Service that contained copies of medical records pertaining to three Jacobi Medical Center patients. The notification letters were sent to each patient in May. He informed the Audit Committee that he would provide the report for all of the privacy complaints received for the second quarter of 2014 - - from April 1, 2014 to June 30th - - at the next Committee in September.

Mr. McNulty then moved along by providing an OCC staffing update. He informed the Committee that the OCC had a vacant position in Central Office. He added that the recruitment process for this vacant position had commenced. Mr. McNulty then commented that, as a result of Mr. Gurin’s appointment to Records Management Officer, the OCC actually had two vacancies at the present. He advised the Committee that Mr. Gurin was previously the Executive Compliance Officer at the South Manhattan Healthcare Network. He advised that there would be a posting for that particular vacancy.

Mr. McNulty continued with the monitoring of excluded providers, informing the Committee that the OCC’s had not receive any reports with regard to excluded providers since the last time the Audit Committee convened. He informed the Committee that the services of a healthcare provider sanction screening vendor, OIG Compliance Now, was procured. He stated that the vendor reviews all employees and other workforce members on a monthly basis to

ensure that workforce members are not on any of the three exclusion lists. He explained that the three exclusion lists are the Department of Health and Service Office of the Inspector General List of Excluded Individuals, the U.S. Government Services Administration List of Excluded Individuals, and the New York State Office of the Medicaid Inspector General Exclusion list. He advised that the vendor would also be reviewing three additional new lists - - the New York State Office of Professional Medical Conduct Misconduct and Physician Discipline List, the New York State OMIG List of Terminations, and the State Disciplinary and Disbarment List. He pointed out that the screening vendor not only looks at the list for New York State to determine whether or not a provider has been disbarred or excluded in New York State, rather the vendor looks at all 50 states. He added that the vendor would have a much more thorough search than what had been performed in the past. Mr. McNulty stated that he looked forward to reporting to the Audit Committee in September with regard to the findings in the last quarter. He closed on this topic by alerting the Committee that the OCC, with the assistance of OLA's outside counsel, Katten Muchin Rosenman, LLP, is finalizing the operating procedure concerning the screening of employees, vendors, and workforce members.

Continuing, Mr. McNulty informed the Committee about his recent meeting with the Chairperson of Gotham FQHC (Federally Qualified Health Center), Inc. ("Gotham"), on the topic of compliance oversight. He informed the Committee that he met with the Gotham Chairperson in April and May to discuss the responsibilities of OCC as it pertains to the Diagnostic and Treatment Centers ("D&TCs") and to talk about the Gotham Board's fiduciary duties with respect to its compliance oversight functions. He elaborated that he met with Gotham Chairperson Dr. Dolores McCray and two other Gotham board members, Paul Covington and Elissa Macklin, as well as with Gotham's Chief Operating Officer, Anita Lee. He informed the Committee that a discussion regarding: (i) the revision of compliance policies and procedures; (ii) the elements of an effective compliance program; and (iii) compliance training for Gotham Board members, took place during the meeting.

Mr. McNulty continuing with page twelve of the Report. He reminded the Committee that in his last Report to the Committee he disclosed that Office of Civil Rights ("OCR") from the United States Department of Health and Human Services ("HHS") performed an audit of Metropolitan Hospital Center ("Metropolitan") with regard to the meaningful access to services and programs for limited English proficient ("LEP") individuals, equal access to services and programs for individuals with HIV, and the privacy and security of protected health information and HIV confidentiality. Mr. McNulty stated that, with the assistance of Metropolitan executive and senior leadership as well as the senior leadership of Central Office, the OCC responded to OCR's query on April 30, 2014. Mr. McNulty, after asking the Committee if they had any questions, concluded his Report.

Ms. Youssouf thanked Mr. McNulty, and then indicated that the Committee was going into Executive Session. (Executive Session was then held).

Ms. Youssouf stated that they are back from the Executive Session and asked for the approval of the Internal Audit Plan 2015, and would like to call for an adjournment. It was seconded and approved.

There being no further business, the meeting was adjourned at 1:08 P.M.

Submitted by,

Emily Youssouf
Chairperson
Audit Committee



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

Corporate Compliance Report

September 11, 2014

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OFFICE OF CORPORATE COMPLIANCE

Corporate Compliance Report
125 Worth Street,
5th Floor Boardroom, Room 532
New York, NY 10013
September 11, 2014 @ 11:00 a.m.

Agenda

I. Compliance Reporting Index

Summary and Prioritization:¹

- 1) For the 2nd quarter of CY 2014 - - April 1, 2014 to June 30, 2014 - - the Office of Corporate Compliance (“OCC”) received a total of 98 compliance-based inquiries and/or compliance-based complaints (hereinafter collectively referred to as “Reports”).
- 2) None of the Reports received by the OCC were classified as a Priority “A” Report.
- 3) There were 64 (or 65.3%) Priority “B” Reports, and 34 (or 34.7%) Priority “C” Reports.

Mode of Reporting:

4) Of these 98 reports, 52 (or 53.1%) were received through the OCC’s anonymous toll-free compliance Helpline (“Helpline”). A summary of the different modes in which the OCC received Reports in the 2nd quarter of CY 2014 is as follows:

- 52 (or 53.1%) received on Helpline
- 22 (or 22.4 %) received via E-Mail
- 15 (or 15.3%) received via Telephone
- 4 (or 4.1%) received via Mail
- 2 (or 2%) received via Face to Face
- 1 (or 1%) received via Office Visit
- 1 (or 1%) received via Other
- 1 (or 1%) received via Voicemail

Allegation Class Analysis:

- 5) The breakdown of the allegation classes of the 98 reports received in the 2nd quarter of CY 2014 is as follows:
 - 24 (or 24.5%) pertained to Policy and Process Integrity
 - 23 (or 23.5%) pertained to Misuse or Misappropriation of Assets or Information

¹ 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.

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- 19 (or 19.4%) pertained to Employee Relations
- 15 (or 15.3%) pertained to Other
- 7 (or 7.1%) pertained to Environmental, Health, and Safety
- 6 (or 6.1%) pertained to Diversity, Equal Opportunity, and Respect in the Workplace
- 4 (or 4.1%) pertained to Financial Concerns

II. Privacy Reporting Index

Incident Reports and Investigations

- 1) There were 36 incidents reported via the HIPAA Complaint Tracking System during the 2nd Quarter of CY 2014 (April 1, 2014 through June 30, 2014).
- 2) After conducting corresponding investigations of the 36 reported incidents, 18 were found to be violations of HHC HIPAA Privacy Operating Procedures; three were determined to be unsubstantiated; 11 were found not to be a violation of HHC HIPAA Privacy Operating Procedures; and four are still under investigation. Of the 18 confirmed violations, 11 were determined to be breaches of protected health information (“PHI”) and seven were determined not to be breaches.

Confirmed Breaches (2nd Quarter CY 2014)

- 3) The following is a summary of the confirmed breaches for the 2nd quarter of 2014.
 - *Coney Island Hospital* – a January 2014 incident that involved the inappropriate access of protected health information (“PHI”) of a patient by a social worker, who later apparently disclosed the patient’s PHI to her personal attorney. Breach notification was sent to the affected patient.
 - *Jacobi Medical Center* – an April 2014 incident that involved the loss of a parcel mailed via USPS that contained copies of medical records pertaining to three patients. The parcel was lost by USPS and never recovered. Breach notification was sent to affected patients.
 - *Harlem Hospital Center* – an April 2014 incident that pertained to the disclosure of a patient’s discharge instructions to another patient. The discharge instructions included PHI such as name, address, medical record number, medications, diagnosis, insurance information, and date of service. When the patient noticed that he/she received the documents in error, the patient contacted Harlem and returned the documents to the facility. Both patients were initially contacted by the facility regarding the incident. Breach notification was subsequently sent to the affected patient.

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- *Jacobi Medical Center* – an April 2014 incident that concerned the disclosure of a patient’s Authorization to Release Information accompanied by a letter from the patient’s lawyer to another patient. The copy service vendor employed by the facility mistakenly sent these documents, which contained PHI such as name, address, date of birth and social security number, to the other patient. The other patient notified Jacobi staff of his/her receipt of documents. Jacobi staff requested that the patient immediately return the documents he/she received and the hospital has since confirmed that the documents were returned to Jacobi. Breach notification, including offer of one-year credit monitoring services, was sent to the affected patient.
- *Harlem Hospital Center* – an April 2014 incident that involved the verbal disclosure of a patient’s PHI to the fiancé of the patient without the patient’s consent or authorization. Disclosure was made by a medical student intern, who was subsequently provided with HIPAA re-education. Breach notification was sent to the affected patient.
- *Queens Hospital Center* – an April 2014 incident that was related to the inappropriate access of a patient’s electronic medical record by five facility employees. One employee was involuntarily separated from services; the remaining four employees were provided with HIPAA re-training by the Facility Privacy Officer. Breach notification was sent to the affected patient.
- *Kings County Hospital Center* – an April 2014 incident that involved the disclosure of eighteen (18) patients’ PHI when a paper document containing their information was discovered on the sidewalk outside of Kings County Hospital. The document was discovered by a SUNY Downstate Medical Center employee and the incident was promptly reported to the Kings HIPAA Privacy Officer. The Privacy Officer was unable to determine the source/owner of the document. Breach notification was sent to all affected individuals.
- *Woodhull Medical Center* – a May 2014 incident that pertained to the disclosure of a patient’s PHI to another patient. The incident occurred when Woodhull issued a hospital wristband containing the PHI to the wrong patient. The wristband included PHI such as the patient’s name and medical record number. Breach notification was sent to the affected patient.
- *Kings County Hospital* – a May 2014 incident that concerned the theft of a bag containing a document with the PHI of a patient. The bag was stolen from a physician’s room at the hospital and a report was filed with Hospital Police. The bag has not been recovered. Breach notification, including an offer of one-year credit monitoring services, was sent to the affected patient.

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- *Lincoln Hospital Center* – a June 2014 incident that involved the unauthorized access of a patient’s PHI contained in Lincoln’s appointment scheduling system, by a Lincoln employee. The PHI inappropriately accessed included the name, financial information and other demographic information of the affected patient. The employee involved in the incident was disciplined and subsequently involuntarily separated from services. Breach notification was sent to the affected patient.
- *Jacobi Medical Center* – a June 2014 incident that was centered on the unauthorized disclosure of a patient’s PHI when an appointment letter was sent to another patient. The letter included name, medical record number, date of birth, and phone number of the affected patient. The patient who received this information noticed the error and immediately returned the appointment letter to the facility. Breach notification was sent to the affected patient.

III. Data Breach at Coler Rehabilitation and Nursing Care Center

- 1) On Friday, August 29, 2014, the OCC began notifying 102 former and current patients at Coler Rehabilitation and Nursing Care Center (“Coler”), formerly the Coler-Goldwater Specialty Hospital and Nursing Facility, concerning the unauthorized access and use of their PHI.
- 2) The incident in question occurred between approximately January 1, 2008 and April 30, 2013, during which period a Coler employee inappropriately accessed and used PHI of Coler patients and filed fraudulent tax returns in their name. The Coler employee subsequently received tax refunds based on the fraudulent tax returns and unlawfully deposited the proceeds derived from the same into accounts under his control. The now former Coler employee was subsequently indicted and is being prosecuted by the United States Attorney’s Office for the Southern District of New York.
- 3) Coler has promptly taken a number of steps in response to this incident, including, among other things, the following:
 - the arrangement for the availability of the services of a third-party vendor to provide affected patients with credit monitoring and identity restoration on their accounts for a period of one year at no cost to the affected patients; and
 - the examination of its internal privacy practices, which will result in, where appropriate, the implementation of policies and procedures to reduce the chance of an incident of this nature from recurring in the future.
- 4) Coler will continue to cooperate with the investigating law enforcement and civil authorities to bring this matter to its proper, just, and prompt conclusion.

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IV. Monitoring of Excluded Providers

- 1) The OCC has not received or uncovered any reports of excluded providers since the Audit Committee last convened in June of 2014.
- 2) As reported to the Audit Committee in June of 2014, the OCC has procured the services of a Healthcare Provider Sanction Screening Vendor – OIG Compliance Now, LLC (“OIGCN”) through an approved third-party contract with the Greater New York Hospital Association/Premier Program. OIGCN provides monthly screening of all HHC workforce members and vendors against the following lists:
 - U.S. Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities (LEIE)
 - U.S. Government Services Administration System for Award Management (SAM) List (formerly EPLS)
 - NYS OMIG exclusions list, and all other states with published Medicaid exclusions lists (or equivalent)
 - NYS OPMC Professional Misconduct and Physician Discipline List
 - NYS OMIG List of Terminations
 - State Disciplinary/Disbarment Lists

V. Gotham Health FQHC, Inc., and Compliance Oversight

- 1) As provided during the April 2014 Audit Committee, HHC applied to the Health Resources Services Administration (“HRSA”) for the designation of its six Diagnostic and Treatment Centers (“D&TCs”) and all of their respective satellite clinics — 20 satellite clinics and 13 school-based health centers — as a Federally Qualified Community Health Center Look-Alike (“Health Center”) pursuant to HRSA's regulations concerning the Public Entity/Co-Applicant governance model. A co-applicant agreement was executed between HHC (“Public Entity”) and the Gotham Health FQHC, Inc. (“Co-Applicant” or “Gotham”) in November 2012.
- 2) With regard to compliance at the Health Center, the Agreement provides that: (i) the Gotham Board of Directors (“BOD”), in conjunction with HHC, shall assure that the Health Center is in compliance with all applicable federal, State, and local laws, regulations and policies; (ii) on at least a bi-annual basis, the Gotham BOD, upon review of periodic reports provided by HHC regarding the Health Center’s legal and regulatory compliance program, shall evaluate the Health Center’s compliance activities and recommend, as necessary, the revision, restructuring, or updating of the compliance program by HHC; and (iii) the applicable provisions of the HHC compliance program shall be deemed the Health Center’s legal and regulatory compliance program.

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3) On July 30, 2014, Mr. McNulty met in person with Gotham Chairperson Dr. Dolores McCray; Gotham Vice Chairperson Elissa Macklin; and Gotham Board Member Paul Covington (collectively “Gotham Board Members”); and Gotham Chief Financial Officer Steve Faas. During the Gotham meeting, the participants discussed several topics related to compliance at the Health Center. A summary of the topics discussed during the meeting is as follows:

(i) Review of the Office of the Medicaid Inspector General’s (“OMIG”) Fiscal Year 2014-15 Work Plan

- Mr. McNulty reviewed the Office of the Medicaid Inspector General (“OMIG”) Fiscal Year (“FY”) 2014-15 Work Plan (“OMIG Work Plan”) with the Gotham BOD, discussing OMIG Work Plan items that related to the Diagnostic and Treatment Centers (“D&TCs”).

(ii) Amendment to HHC’s Compliance Plan and HHC Operating Procedure (“OP”) 50-1 (Corporate Compliance Program)

- Mr. McNulty advised the Gotham BOD that in the upcoming months the HHC Compliance Plan would be revised to specifically reflect the Health Center’s regulatory requirements under 10 NYCRR §§ 751 et seq., and would include any specific HRSA requirements related to the HHC Compliance Plan.
- Mr. McNulty informed the Gotham Board that the amended HHC Compliance Plan will reflect, among other things, HHC’s new compliance policies covering overpayments; billing practices; medical record documentation; and federal program exclusion checks.
- With regard to HHC Operating Procedure 50-1, the Gotham Board was advised that HHC OP 50-1 was being amended to incorporate, among other things, compliance responsibilities related to the Health Center.

(iii) The Development of Several Compliance Operating Procedures

- Mr. McNulty advised the Gotham BOD that the OCC was in the process of finalizing an OP on provider sanction screening. He noted that the OP outlines: (i) the Corporation’s screening and monitoring process used to identify and, when appropriate, preclude employment or the establishment of business or volunteer relationships with individuals and entities who have been excluded from participation in federal healthcare programs; and (ii) the process by which any necessary self-reporting to appropriate authorities will be performed.

- The Gotham BOD was informed that the OCC was in the process of finalizing OPs covering Overpayments, Billing and Claims Reimbursement, Medical Record Documentation, and the Emergency Medical Treatment and Labor Act.

VI. External Audits – U.S. Department of Health and Human Services (“HHS”) Office of Civil Rights (“OCR”): *Follow Up Report*

1) The OCC reported to the Audit Committee in June that it responded to a review being conducted by the Office of Civil Rights (“OCR”) concerning Metropolitan Hospital Center’s (“MHC”) compliance with certain federal civil rights and health information technology laws, including MHC’s policies, procedures, and practices related to: (i) meaningful access to services and programs for limited English proficient (“LEP”) individuals; (ii) equal access to services and programs for individuals with HIV; and (iii) the privacy and security of individuals’ protected health information (“PHI”) and their rights with regard to such information.

2) The OCR subsequently requested additional information regarding the scope of HHC’s risk analysis process, specifically asking for a comprehensive risk analysis which identifies risks and vulnerabilities for the organization-wide electronic PHI (“E PHI”) systems and applications including, but not limited to, servers, applications, databases, desktops, mobile devices and media, or smartphones, that contain, process, or store E PHI, as well as MHC’s corresponding remediation plan and targeted completion dates.

3) As a result of OCR’s new query, on July 28, 2014, the OCC provided a supplement to its initial response. Therein, the OCC provided an overview of HHC’s past and present data security activities including the following:

- findings from a vendor conducted information security and HIPAA assessment of MHC;
- a MHC Risk Registry and Remediation and Tracking report;
- a HIPAA Risk Analysis Report of MHC’s Quadramed system; and
- the engagement of the services of an outside information technology vendor to perform a risk assessment and HIPAA gap analysis on all HHC acute care facilities, including MHC.