



**NEW YORK CITY  
HEALTH AND HOSPITALS CORPORATION**

Management Letter

June 30, 2011



KPMG LLP  
345 Park Avenue  
New York, NY 10154

September 29, 2011

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

Ladies and Gentlemen:

In planning and performing our audit of the financial statements of New York City Health and Hospitals Corporation (the Corporation), a component unit of the City of New York, as of and for the year ended June 30, 2011, in accordance with auditing standards generally accepted in the United States of America, we considered the Corporation's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we do not express an opinion on the effectiveness of the Corporation's internal control.

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

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

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**NEW YORK CITY  
HEALTH AND HOSPITALS CORPORATION**

**Matrix of Observations**

**June 30, 2011**

Network	Facilities Audited in 2011	Corporate Challenge and Mission	Unusual Transactions Review	Information Technology	Affiliations	Corporate Compliance	Payroll and Human Resources	Journal Entries	Materials Management	Accounts Receivable and Patient Revenue	Cash Receipts	Bank Reconciliations
Corporate		X	X		X	X				X		
Generations + Northern Manhattan	Lincoln Medical & Mental Health Center									X		
Southern Brooklyn/ Staten Island	Coney Island Hospital											
North Bronx	North Central Bronx Hospital											
Queens	Queens Hospital Center											
South Manhattan	Bellevue Hospital Center											
	Gouverneur Nursing Facility D&TC						X					
North Brooklyn	Cumberland D&TC											



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## **General Industry**

### **The Challenge of The Corporation and Its Mission**

#### ***Observation (Repeat Comment)***

The Corporation's mission continues to be providing healthcare services to a substantial number of uninsured patients.

The Corporation has incurred operating losses in the past three years as a result of declining revenues and increasing expenses such as employee benefits.

The Corporation faces challenges pertaining to healthcare reform legislation, changes in Federal and State healthcare reimbursement regulations and continuous managed care market increases. As a result of federal healthcare reform legislation, substantial changes are anticipated in the United States healthcare system. Such legislation includes numerous provisions affecting the delivery of healthcare services, the financing of healthcare costs, reimbursement of healthcare providers and the legal obligations of health insurers, providers and employers. These provisions are currently slated to take effect at specified times over approximately the next decade. Most of the impact of the new legislation will begin impacting hospitals in 2014.

The blending of all these factors means that, going forward, the financial picture of the Corporation may continue to be one of expenses exceeding revenues.

The Corporation has been aggressive in dealing with its challenges in a number of ways, including the following initiatives:

- Identifying revenue enhancement strategies
- Identifying cost reduction opportunities
- Instituting a hiring freeze
- Execution of a restricting plan that includes right sizing and clinical consolidations

#### ***Recommendation***

We encourage management and the Board to continue to focus on such initiatives and take the necessary actions to ensure that the Corporation's funding remains adequate in order to carry out its vital mission.

#### ***Management Response***

The Corporation is monitoring full-time-equivalent (FTE) employee levels to ensure that they are appropriate and has instituted a hiring freeze, with certain exceptions approved by our Vacancy Control Board. During 2011, the Corporation reduced its FTE's by 1,322 or 3.5%.

The Corporation has selected a new Siemens patient billing and access system that, among other things, will ensure that we optimize our collection of revenue due from third-party payors for all services provided to our patients. Collaborative teams from Corporate Finance and the facilities have begun the complex and time-consuming work of preparing for a system-wide implementation that will span the next several years.



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As part of the Corporation's Breakthrough Initiative, the Corporation plans to continue to improve charge capture and efficiency in Emergency Departments and Operating Rooms. Also, the Corporation is refining the methodologies for implementing Profit and Loss by Service Line reporting for our acute care facilities, which should help monitor and improve facility performance.

Also, the Corporation, with data from a consultant's review of Network structure, services and operations, has begun to explore and implement restructuring recommendations to improve efficiency.

We recently have changed our operating procedures to channel our procurement through centralized contracts that ensure that we can use our vast purchasing volume to obtain the lowest possible price. As part of this effort, we will continue to work with our physicians to forge consensus around standardizing our use of certain medical and surgical supplies to leverage volume and lower costs. Also, we have contracted with a prime distributor for medical and surgical supplies, as we have done successfully in the past with pharmaceuticals, to lower our inventories and costs and ensure just-in-time delivery of an array of products from a single distribution source. The Corporation has also consolidated contracts for environmental services, offsite storage and office supplies that will significantly reduce expenses.

MetroPlus membership has increased by 10% in 2011, and has recently reached a level of more than 415,000 members.

The Corporation increased net patient service revenue by \$536.5 million for Disproportionate Share (DSH), Upper Payment Limit (UPL) and Supplemental Medicaid Managed Care funds as we continue to secure additional funding from Federal and State sources to support the Corporation's operations. Prior year's Outpatient UPL for the State fiscal years ending 2007, 2008 and 2009 had been received during 2011 in the amount of \$586.8 million and helped in maintaining positive cash flows. The Corporation anticipates the remaining DSH and UPL for prior years to be paid by the end of 2012.

A review of the Corporation's historical financial performance shows that it has reported losses on an accrual basis for multiple consecutive years, followed by several years of positive bottom-lines. Going forward, reporting a positive bottom-line on an accrual basis will be increasingly difficult since the Corporation implemented Governmental Accounting Standards Board Statement No. 45, requiring the annual recognition of a noncash OPEB liability (approximately \$531 million in 2011). However, it is important to note that, throughout the Corporation's existence, it has always ended its fiscal year with an adequate, positive cash balance. In partnership with the City, we will continue to do all that we can to articulate a clear picture of how proposed Federal and State actions would impact the Corporation and the communities we serve.



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## Corporate

### Unusual Transactions Review

#### *Observation*

KPMG noted that management's evaluation of the North General lease agreement for financial reporting implications was not performed in a timely manner.

#### *Recommendation*

Management should ensure that the execution of all non routine transactions are reviewed for financial reporting purposes on a timely basis.

#### *Management Response*

Management recognizes its responsibility to ensure that non routine transactions are reported accurately and timely on HHC's financial statement. New procedures are currently in place to review all new non routine transactions for financial reporting implications. Working with the Office of Legal Affairs, Corporate Finance will ensure that all pertinent information is available to determine the proper financial reporting of such transactions in a timely manner.

### Accounts Receivable and Patient Revenue

#### *Observation*

During our fieldwork over the valuation of accounts receivable, KPMG noted the following:

- Management's valuation methodology addresses net accounts receivable, contractual allowances, and the allowance for doubtful accounts however the allowance for doubtful accounts collection study was not updated as management is in the process of updating the valuation methodology process.
- Management's valuation methodology over patient accounts receivable does not consider debits and credits separately.

#### *Recommendation*

KPMG recommends that management analyze all aspects of the valuation of accounts receivable (contractual allowances, allowance for doubtful accounts and credits) and monitor the components on a quarterly basis to ensure that the estimated value is accurately stated.

#### *Management Response*

Management is transitioning to a more efficient methodology for determining the net accounts receivable. During this transition, more accurate information has been gathered through the Siemens billing system and calculations are being performed using more current software. Additional work will be performed during 2012 to streamline the process for calculating the net receivable. Working with Siemens, management anticipates that an analysis of contractual allowances, allowance for doubtful accounts and credits will be integrated into the new methodology.



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## **Affiliation Contracts**

### ***Observation (Repeat Comment)***

Affiliation contracted services is a significant expense for the Corporation and the monitoring of the expenses associated with these contracts requires the cooperation of various departments both within and outside the Corporation.

While we did not perform a compliance audit on the affiliation contracts, we noted the following during the course of our testwork in conjunction with the review of the compliance audits performed by HHC's Internal Audit:

- Several of the contracts were executed after the commencement of the contract period, in some cases more than a year later.
- Recalculation documents are not prepared on a timely basis resulting in potential future adjustments. Additionally, certain affiliates do not provide fee statements as required by the contract.
- Lack of timely completion of the requested compliance audit for one of the affiliation contracts.
- The compliance audits identified instances where there was a lack of written documentation to support payments to subcontractors, instances where not all affiliated physicians prepared timesheets to support time spent in performance of contract services or did not complete time study allocation forms, and a lack of compliance with background checks in accordance with the contract services.
- Similar to the prior year, Columbia University Medical Center chose not to provide a response to the audit confirmation requested by the Corporation. Additionally, we note that Columbia has a history of not providing recalculation documents, confirmation replies, and documentation supporting its costs.

### ***Recommendation***

We noted the following areas for improvement:

- Affiliation contracts should be executed prior to commencement of the contract period. Additionally, the status of all agreements, including the dates on which the contracts were signed should be communicated to the board of directors.
- Reconciliations between the Affiliate and the facilities should be performed timely in accordance with the contract.
- Audits for the affiliation contracts should be completed timely for all Affiliates.
- Management should enforce procedures so that the Affiliate secures written approval for all subcontractors before they are made in accordance with the terms of the contract.
- Management should enforce the contract terms whereby the Affiliate is required to provide complete and accurate time sheets for service providers working under the affiliation contract.



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***Management Response***

Management agrees that affiliation contracts should be signed prior to the commencement of the contract period, however, due to the complex nature of the financial terms of the contract that has not always been possible.

Management also agrees that recalculations (final settlement schedules) should be completed more timely. Per the affiliation contract, reconciliation of affiliate payments should be performed on a semi-annual or annual basis through the recalculation process. The Office of Professional Services and Affiliations (OPSA) monitors the facilities on the timeline for submission, and if reconciliations become past due, OPSA communicates with the facilities. At present, no Affiliate payment is adjusted for monies due the Affiliate until the fee statements (schedules of costs incurred) and recalculation documents are fully executed per the contract.

Affiliates are required to submit payroll reports and fee statements to the facility, however, certain affiliates do not submit these documents until they prepare their recalculation schedules. OPSA will again recommend to the facilities and affiliates that they review these monthly reports and track affiliate payroll against the approved budget to identify any unapproved actions on a monthly basis. Any findings should be discussed between the facility and the affiliate during Joint Oversight Committee (JOC) meetings.

To ensure timeliness of the auditing of the affiliation contract, the Corporation's Office of Internal Audits (OIA) has assumed the function of conducting the audits in-house, in lieu of contracting out, which had been the past practice. OIA has started the audits earlier in the year, enabling conclusion of fieldwork more timely, expediting exit conferences, and combining the findings for multiple facilities under the same affiliate where the findings are identical.

All affiliation contracts require the affiliates and facilities to conduct JOC meetings. These meetings function as the mechanism for discussions of operational and financial issues related to the contract. Oversight of this process has recently been strengthened by requiring the facility to submit detailed minutes of JOC meetings to the Corporations' Chief Operating Officer (COO) and Chief Financial Officer (CFO) and their respective designee on a monthly basis. In addition, OPSA has begun conducting quarterly meetings with the COO, CFO and designee(s) to report on issues specific of each contract. Issues discussed include items such as actual expenses versus budget, JOC processes and key decisions (attrition, vacancies, backfills, operational issues, compliance with contracts, plans related to backfills, sub-contracts and new programs).



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## **Corporate Compliance Program**

### ***Observation***

The focus by both State and Federal regulatory and enforcement environment pertaining to both Medicare and Medicaid fraud is at an all time high. The Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (“Healthcare Reform”), strengthened existing healthcare fraud and abuse and program integrity provisions and made significant changes to existing civil, criminal, and administrative anti-fraud statutes. Additionally, New York State OMIG’s Bureau of Compliance continues to focus on the legislation enacted in 2009 Part 521 entitled “Provider Compliance Programs” that was added to Title 18 of the Codes, Rules and Regulations of the State of New York. Several of the key provisions making this standard one of the strictest in the nation are as follows:

- The expansion of the program beyond billing and reimbursement to require inclusion of areas including medical necessity and quality of care, governance, mandatory reporting, credentialing, and other risk areas that are or should with due diligence be identified by the provider.
- The requirement to certify in writing that the organization has an effective compliance program.
- The authority of the State Commissioner of Health and the Medicaid Inspector General to exclude any provider from the Medicaid program if it is determined that the organization does not have an effective compliance program.

It is clear from statements in widely available literature that the OMIG expects that senior executive leadership and the board of directors of organizations take sufficient ownership of the compliance program and process to ensure that it is adequately designed and implemented in a manner that ensures the program will be effective overall.

While we did not perform a comprehensive assessment of the compliance program that would enable us to observe the comprehensive program and therefore comment on the overall design and degree of implementation of the program, we were able to make observations on certain important aspects of the program and wish to communicate these to the Corporation.

In the context of the information provided above, KPMG notes the Corporate Compliance process continues to evolve and highlights include:

- CEO and other executive and board leaderships continued recognition of the importance of the program.
- Centralization of the compliance program so that network compliance officers now directly report to the Chief Compliance Officer.
- Risk assessment process, although conducted in an expedited manner, that utilized a computer assisted tool in order to develop the Annual Compliance Plan through a series of questions distributed to a wide variety of individuals throughout the Corporation.



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Additionally, the following was noted through interviews and observation:

- a. Turnover of 5 network compliance leaders from both the Network and Compliance Officer (NCO) and Associate Compliance Officer (ACO) ranks. This reduction in the size of the compliance staff, although potentially temporary, may put a strain on the current resources which will need to be monitored to ensure continued effectiveness and evolution of the program.
- b. Need for enhanced communication between compliance leadership and compliance staff especially with regards to:
  - i. Items being discussed with the HHC Board and the associated implications to the evolution of the compliance program, and
  - ii. Items being discussed with the Executive Compliance workgroup and the associated implications to the evolution of the compliance program (this was noted in the 2010 management letter comment);
- c. A lack of readily verifiable evidence supporting key monitoring plans to show that these plans were consistently and effectively implemented across the applicable networks within the Corporation. These monitoring plans were said to be developed as part of the 2010 risk assessment process.
- d. A program that does not yet clearly describe the necessary linkages between medical necessity and quality of care and compliance (as mandated in Part 521), such that an external reviewer would clearly understand the linkages in a way that allowed for them to be deemed comprehensive and effective.

### ***Recommendations***

As the Corporate Compliance Program continues to evolve, KPMG recommends the following:

1. Test the stated existence and implementation across all networks of monitoring plans applicable to the 2010 risk assessment process.
2. Review documentation to support the key monitoring plans to ensure that a regulator would be able to deem them effective as has been stated in the annual NY State OMIG certification process.
3. Review the existing quality and compliance forums to determine if improved linkages and communication between such forums is optimal.

### ***Management Response***

HHC's Corporate Compliance Program (Program) covers all eight (8) elements of an effective provider compliance program set forth under the Department of Social Services' mandatory compliance program regulations. The Program also adopts the principles stated in the 2010 Federal Sentencing Guidelines concerning effective compliance and ethics programs.



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As part of HHC's Program strategies, HHC's Governing Body plays a significant role in fostering an effective compliance program. Particularly, in addition to the compliance oversight activities employed by the Audit Committee of the Board of Directors (Board), the Quality Assurance Committee of the Board addresses quality assurance, provider credentialing, and the granting of provider privileges as required under the Public Health Law. Further, as mandated by HHC's operating procedure, HHC's Chief Medical Officer (CMO)/Senior Vice President of Quality serves on HHC's Executive Compliance Workgroup (ECWG), and, like other ECWG members, provides guidance to the Corporate Compliance Officer (CCO) on compliance issues and initiatives. In the end, the goal of HHC and its Office of Corporate Compliance (OCC) is to ensure that quality-related risk items are addressed with Board oversight either through the Quality Assurance Committee or the Audit Committee of the Board. For example, in HHC's CY 2011 Corporate Compliance WorkPlan, there are several quality issues being addressed by the OCC (with Audit Committee oversight) including radiology quality assurance and human subject research protections. Moving forward, the OCC will continue to work with HHC's CMO on addressing compliance issues related to medical necessity and quality of care, and credentialing. In addition to the foregoing, HHC's Governing Body has received compliance training twice in the past three years during its annual educational sessions. Further, each member of HHC's Governing Body has completed mandatory training concerning corporate responsibility as required under the Public Authorities Accountability Act.

With regard to HHC's annual compliance WorkPlan process, every risk item currently goes through at least three cycles of review: (1) an assessment cycle to determine the level of risk present; (2) a mitigation cycle to implement a plan of correction; and (3) a monitoring cycle to review, and, where appropriate, to audit any internal controls established to mitigate the underlying risk. Additionally, after the monitoring cycle is completed, all risk items are further assessed to determine whether a post-review cycle is warranted at specified time horizons. Moreover, HHC updated its Corporate Compliance Plan earlier this month, underscoring therein, among other things, several key themes: (i) the significant roles corporate governance, quality assurance, and patient safety all play in implementing an effective compliance program; (ii) the importance of the development of written policies and procedures designed to prevent fraud, waste, abuse, and criminal and/or unethical conduct; and (iii) the crucial role corporate training and education have in HHC meeting its mandatory compliance program activities. Finally, over the next several months, the Program will be reassessing its risk assessment methodology as it develops its calendar year 2012 Corporate Compliance WorkPlan.

Lastly, it is important to point out that the OCC has been under new leadership since mid-September of 2011. As a result, the Program's staffing structure and operations have undergone strategic changes in an attempt to strengthen its human resources and maximize the effectiveness of corporate compliance activities, respectively. More to the point, the OCC acknowledges that effective lines of communication between compliance leadership and compliance staff are a crucial piece in developing and maintaining an effective corporate compliance program. To that end, compliance leadership will keep compliance staff apprised of Board-related and ECWG compliance activities as it deems necessary to: (i) facilitate an effective compliance program; and (ii) to enable staff members to carry out their compliance program duties in an informed, efficient, and productive manner. Additionally, OCC staff members are scheduled to undergo training in medical auditing, privacy and confidentiality, and human subject research protections in the near future. In short, OCC has taken (and will continue to take) appropriate steps to strengthen and retain its human resources.



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**Network: Generations Plus Northern Manhattan Network**

**Accounts Receivable and Patient Revenue**

***Observation***

During our fieldwork at Lincoln Medical and Mental Health Center, we noted that the open visit report had 156 visits that were one year or older, evidencing that timely follow up on open visits is not performed.

***Recommendation***

The facility should implement periodic reviews of the open visit report to ensure that open visits are closed (cash is collected, contractual allowances are taken, and/or uncollectible balances are written off) in a timely manner.

***Management Response***

Lincoln will continue to monitor the open visits report and will comply with controls in order to investigate and close all visits in a timely manner.



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**Network: South Manhattan Network**

**Payroll and Human Resources**

***Observation***

During our field work at Gouverneur Nursing Facility D&TC, the facility profile report did not include an additional hour worked by the employee per the time sheet and as a result the employee was not paid for all hours worked.

***Recommendation***

Gouverneur Nursing Facility should implement procedures to ensure that employee hours worked are accurately entered into the payroll system so that the employees are paid for all hours worked.

***Management Response***

Gouverneur Nursing Facility D&TC will require all payroll timekeeping staff to take a refresher course on the timekeeping process to ensure that the staff acquires the appropriate timekeeping codes and necessary authorization forms. In addition, Gouverneur payroll supervisors will periodically perform reconciliations between approved time sheets and the computerized facility timekeeping profile to ensure that timekeeping staff is entering correct information.

\* \* \* \* \*

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

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

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

Very truly yours,

**KPMG LLP**

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### **Prior Year Comments Cleared**

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

#### **Information Technology**

##### ***Observation***

We noted that the disaster recovery test scheduled for April 2010 was canceled and no disaster recovery test was performed in fiscal year 2010.

##### ***Resolution***

The disaster recovery test took place on December 17, 2010.

#### **Internal Audit**

##### ***Observation***

Given the current environment in which the Corporation operates, a strong internal audit program is key to the safeguarding of the Corporation's assets as well as compliance with Corporate policies and procedures. Presently, the network internal auditors do not report to the Chief Internal Auditor.

##### ***Resolution***

Since the hiring of the Chief Internal Auditor in April 2010, an assessment of the skill set of the Internal Audit department has been completed. Review of education and related skills has identified that all professional staff possess Baccalaureate Degrees in an appropriate major; four professionals have Masters Degrees (one has a Doctorate); and four members have professional certifications. In addition, six members of the department have recently attended internal auditing training courses provided by the Institute of Internal Auditors. The Internal Audit department benefits from an indirect (dotted line) reporting relationship with the Audit Committee of the Board, which enhances communications.

Effective January 1, 2011, the Network internal auditors began reporting to the Chief Internal Auditor.

**Network: Generations Plus Northern Manhattan Network**

**Accounts Receivable and Patient Revenue**

***Observation***

During our fieldwork at Renaissance Health Care Diagnostic & Treatment Center, we noted the following:

- An outpatient account had charges not attached to a visit and was not billed.
- An outpatient account had no activity or proper follow up since the bill was originally generated in October 2009.
- An outpatient account was not properly re-billed after a denial occurred.

***Resolution***

Renaissance Health Care Diagnostic & Treatment Center implemented monitoring procedures over outpatient accounts receivable to ensure timely resolution of issues in such areas as unbilled or uncollected balances and denials.

## **Network: Central Brooklyn Network**

### **Accounts Receivable and Patient Revenue**

#### ***Observation***

During our fieldwork at Kings County Hospital, we noted the following items:

- An outpatient account did not have the proper fee scale indicator entered into the system, causing it to not be properly fee scale adjusted.
- The open visit report had 144 open visits as of June 30, 2009.

#### ***Resolution***

Kings County Hospital implemented periodic reviews of the outpatient accounts receivable balances to ensure accurate fee scaling of accounts. In addition, periodic reviews of the open visit report were conducted to identify open visits generating in the preceding fiscal year which require closing.

### **Cash Receipts**

#### ***Observation***

During our fieldwork at Kings County Hospital, we noted that there was no reconciliation performed over cash receipts for credit cards to the cash control log.

#### ***Resolution***

Kings County Hospital implemented a daily reconciliation process for all credit card receipts received to the daily cash control log in January 2011.

### **Payroll and Human Resources**

#### ***Observation***

During our fieldwork at Kings County Hospital, we noted that there was a discrepancy between the facility profile report (computer generated report showing employee hours worked) and the approved timesheet.

#### ***Resolution***

Kings County Hospital implemented a periodic review process to ensure time worked as per the approved time sheet is correctly reflected in the facility's profile report.

**Network: Southern Brooklyn/Staten Island Network**

**Journal Entries**

***Observation***

During our fieldwork at Sea View Hospital Rehabilitation Center and Home, we noted that certain journal entries were either not properly approved or not supported by adequate documentation.

***Resolution***

Effective November 1, 2010, the Controller/Designee began signing, reviewing and approving all postings prior to input and ensuring all relevant documentation is attached.

**Payroll and Human Resources**

***Observation***

During our fieldwork at Sea View Hospital Rehabilitation Center and Home, we noted that there was a discrepancy between the facility profile report (computer generated report showing employee hours worked) and the approved timesheet.

***Resolution***

As of January 2011, the Director of Payroll began performing random reconciliations between approved time sheets and the computerized facility timekeeping profile to ensure that timekeeping staff is entering correct information each pay period.

**Network: North Bronx Network**

**Accounts Receivable and Patient Revenue**

***Observation***

During our fieldwork at Jacobi Medical Center, we noted the following:

- An outpatient account bill was rejected, and not re-billed or followed up to conclusion.
- An outpatient account was billed and paid by the primary insurance. The remaining coinsurance balance was then billed to the secondary insurance which subsequently rejected the claim. After the rejection, the claim was not rebilled.
- An inpatient account had an incorrect allowance entered into the system for no fault insurance thereby not alerting the facility to follow up with no fault insurance for payment.

***Resolution***

Network Management continues to monitor and train staff on the procedures to eliminate front end rejections and implemented a process and procedure for following up on denials related to insurances to ensure that secondary balances get billed to the appropriate payor. Staff training regarding changing effective dates of insurance plans has helped to eliminate these findings. Staff has been instructed to escalate to management any billing rejections that they cannot correct, so they may be followed up appropriately. Inpatient Accounts Receivable management has developed a procedure to review and monitor inpatient manual allowances as it relates to No Fault cases.

**Network: South Manhattan Network**

**Accounts Receivable and Patient Revenue**

***Observation (Repeat Comment)***

During our fieldwork at Bellevue Hospital Center, we noted a Medicare psychiatric inpatient account where the patient needed to have a combined claim due to the discharge and readmission dates being within three days of each other. The combined claim was not generated until after the sample was chosen by KPMG for testing.

***Resolution***

A process has been implemented effective July 1, 2010 in Bellevue's Upfront Unit to identify these types of admissions. All Medicare, psychiatric and rehabilitation admissions are reviewed by respective Unit personnel (Hospital Care Investigators (HCIs)) and Unit supervisory staff, (which includes Sr. Health Care Program Policy Analyst's (HCPPA's), and Senior HCIs) to confirm that patients have not been discharged seventy-two hours or less from the new admission date/time. Any instances whereby discharge and admission are within a seventy-two hour window are reported to the Associate Director for investigation to ensure that first and second admission dates of service are submitted on the same claim.