ALAMEDA
HEALTH SYSTEM

AUDIT AND COMPLIANCE COMMITTEE MEETING

TUESDAY, March 19, 2013

Central Administration Offices Located at Highland Hospital
1411 East 31st Street Oakland, CA 94602
Barbara L. McElroy, Clerk of the Board
(510) 437-8468

LOCATION:

Open Session: E3-19 Conference Room

COMMITTEE MEMBERS

Kirk E. Miller, ***Chair***
Daniel Boggan, Jr.
Valerie D. Lewis, Esq.

MINUTES

TAB #1 CLOSED SESSION

OPEN SESSION – THE MEETING WAS CALLED TO ORDER AT 4:00 PM

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT:

Kirk E. Miller, Daniel Boggan, Jr., and Valerie D. Lewis, Esq.

TAB #2 Approval of Minutes

ACTION: A motion was made, seconded and unanimously approved the minutes of the October 23, 2012 Audit and Compliance Committee meeting as presented.

MOTION: Trustee Lewis
SECOND: Trustee Boggan

AYES: Trustees Miller, Boggan, and Lewis
NAYS: None
ABSTAIN: None
ABSENT: None

TAB #3 Old Business

A. **None**

TAB #4 External Audit Reporting

A. **INFORMATION: External Audit Services Contract Renewal**
Mr. Kibler presented an overview of the Macias Gini & O'Connell (MGO) contract for FY2013 – FY2015. MGO will continue to perform the financial audit for the Medical Center and the Foundation as well as performing the single audit of the significant grant programs. The negotiated rates reflect an increase of 2.5% for FY2013 and increases based on the Consumer Price Index not to exceed 3% for the subsequent 2 years. Trustee Lewis inquired as to whether the topic of length of duration with the same audit firm was discussed by the committee when the audit evaluation and recommendation to continue with MGO was discussed. The members of the committee confirmed that this topic was discussed.

TAB #5 Internal Audit Reporting

A. **REPORT: Update on FY2013 Internal Audit Annual Plan**
The FY2013 internal Audit plan was approved at the July 24, 2012 Audit and Compliance Committee meeting. Planned projects of Credit Balances and DSRIP DY07 have been completed. Reviews of Denial Management, FQ Billings, Medi-Cal timely Filing and Collection/bad Debts are in process. The Audit Plan is considered on schedule to be completed by year-end.

B. **REPORT: Status on FY2010, FY2011, and FY2012 External Financial Audit Management Letter Action Plan**
Internal Audit has reviewed the status of findings from the MGO annual financial audits. Corrective Action has been initiated for all findings from the FY2011 and FY2012 audit and all items are considered resolved. There is one outstanding item from the FY2010 audit relating to IT Strategy and controls that is still considered outstanding. There will be a presentation at the April 2013 Board Retreat to address the IT Strategy.

Trustee Miller stated that he would like to discuss the difference between the IT Strategic Plan and the Electronic Health Record (E.H.R.) Plan approved previously by the Board of Trustees when the IT Strategic Plan is presented.

C. **REPORT: DSRIP DY7**
In conjunction with the FY2013 Annual Audit Plan, Internal Audit completed a review of Delivery System Reform Incentive Payments (DSRIP) DY07. The review focused on the documentation supporting the achievement of milestones for the DSRIP program as reported to the state. For DY07, ACMC had identified 33 milestones totaling approximately $42M in funding requests. During the course of the review, Management provided sufficient documentation to support the achievement of all 33 identified milestones.

Trustee Miller requested the development of a Policy and Procedure to identify access and security for the documentation files to ensure they were available when needed.

D. **REPORT: Credit Balances**
In conjunction with the FY2013 Annual Audit Plan, Internal Audit has completed a review of credit balances to determine if credit balances were being reported accurately, processes creating credit balances were appropriate and accounts with credit balances were being worked on a timely basis. Internal Audit identified 4 items relating to control deficiencies in credit balance processing. All items were resolved during the course of the audit.

TAB #6 Compliance Update

A. **REPORT: Compliance Program Update**
Mr. Habig provided an update on the Compliance Program. A Compliance Steering Committee consisting of the General Counsel, Chief Financial Officer, Vice President of Quality, Chief Information Officer, Director Internal Audit and Director Patient Accounting has been established and meets regularly to address and resolve potential compliance issues that have been identified. As a result of this committee, an additional committee consisting of General Counsel, Vice President of Quality, Chief Information Officer, Director Internal Audit and Privacy Officer has been formed to address ongoing HIPAA issues. Mr. Habig also provided an update on recruiting efforts for the Compliance Analyst position reporting to him.

The Trustees requested the Chief Compliance Officer to provide a more detailed plan for the compliance program, including an analysis of the compliance risks faced by the organization, identifying those areas that bear the most risk, and a work plan to ensure risks are identified, prioritized and addressed on a timely basis.

TAB #7 **Annual Audit and Compliance Committee Agenda Calendar and Follow-up**

A. **DISCUSSION: Annual Work Plan for the Committee**

B. **INFORMATION: Audit and Compliance Committee Master Calendar and Follow-up Worksheet**

TAB #8 **Reading Materials**

A. **None**

TAB #9 **REPORT: Legal Counsel's Report on Action Taken in Closed Session**

Douglas B. Habig, General Counsel, reported in Closed Session the committee reviewed matters pertaining to significant exposure to potential litigation: no action was taken.

Public Comments: None.

Board of Trustees Remarks: None.

ADJOURNMENT: THE MEETING WAS ADJOURNED AT 5:20 PM

Respectfully Submitted by:

Barbara L. McElroy
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____
Douglas Habig, Esq.
General Counsel