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November 22, 2011

Jacqueline Alpert
Contracts Officer
Department of Healthcare Finance
899 North Capitol Street, N.E., 6th Floor
Washington, D.C. 20002

Dear Ms. Alpert:

In response to the Solicitation Number DCHT-2011-R-0010, United Medical Center Independent Review, RSM McGladrey, Inc. (McGladrey), and its teammates, Health IT 2 Business Solutions, LLC and Decisive Consulting Solutions, LLC, collectively The McGladrey Team, have been engaged to perform an assessment of the sustainability of the Not-for-Profit Hospital Corporation's (d/b/a United Medical Center and referred to in our report as UMC or the Hospital) business in light of the pending healthcare reform, as well as review UMC's financial and business operations and liabilities considering the Hospital's existing payor mix and the nature and amount of the reimbursement the Hospital receives from the District of Columbia's Medicaid program.

The McGladrey Team of selectively chosen and strategically aligned experts is a diverse, seasoned and cohesive execution unit, inclusive of a deeply experienced minority business consistently rated "Outstanding" by clients in the Healthcare industry. Our team's experience includes successful service to healthcare and public sector entities of similar or greater size and complexity. The McGladrey Team is representative of vast resources and the nation's top professionals working as one.

This report is intended solely for the information and use of the District of Columbia Department of Health Care Finance, UMC Boards of Directors, and UMC management and is not intended to be and should not be distributed or used by anyone other than these specified parties. It will be our pleasure to respond to any questions you have regarding this report. We appreciate the opportunity to be of service to the District of Columbia Department of Health Care Finance.

Sincerely,

RSM McGladrey, Inc.

RSM McGladrey Inc.

District of Columbia
Department of Health Care Finance

United Medical Center Independent Review

November 22, 2011

Experience the power of being understood.[SM]

McGladrey

RSM McGladrey, Inc.

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Executive Summary

In Review

The people of the District of Columbia (the District), including those in Wards 7 and 8, deserve easy access to high clinical quality healthcare. At all service levels, those in Wards 7 and 8 should have access to healthcare that meets the same standards found in Wards 1 through 6. Given the on-going changes for over a decade, the Not-for-Profit Hospital Corporation d/b/a United Medical Center (UMC or the Hospital) needs the opportunity to stabilize. All stakeholders are best served if the ownership and tax status of UMC does not change for a three year period.

Recommendation

- We believe it is important to shift the emphasis from being "hospital centric" to being "ambulatory and physician centric" to stabilize UMC and provide a pathway for sustainability, regardless of the shape healthcare reform takes moving forward.

A "hospital centric" environment is a pattern of health care in which a patient is treated for a brief but severe episode of illness, for complications resulting from an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital by specialized personnel using complex and sophisticated technical equipment and materials, and it may involve intensive or emergency care. This pattern of care is often necessary for only a short time.

An "ambulatory and physician centric" environment involves medical care including diagnosis, observation, treatment and rehabilitation that is primarily provided on an outpatient basis, rather than by admission to a hospital. Ambulatory care is given to persons who are able to ambulate or walk about. A well-baby visit is considered ambulatory care even though the baby may not yet be walking. Such medical care would be provided through a strong network of physicians and medical professionals. Services may be part of a hospital, augmenting its inpatient services, or may be provided at a free-standing facility.

The future sustainability of UMC is a pressing matter for the residents of Wards 7 and 8, along with numerous stakeholders inside and outside of the District. As such, we believe a premature sale or transfer of UMC's assets may result in continued instability, loss of the investment made by the District and/or the possibility that the new owner will move in a direction which may not meet the acute healthcare needs of the District and the people of Wards 7 and 8.

Under the District of Columbia Home Rule Act, the District Office of the Chief Financial Officer (OCFO) has oversight, authority, and responsibility for virtually all financial aspects of each agency within the District. This includes, but is not limited to, cash management, procurement, disbursement processing, administrating financing arrangements, and financial accounting and reporting. As an agency of the District, UMC is not exempt from this Act. Therefore, the structure of this oversight, authority and responsibility should be tailored to satisfy both the provisions of the Act, as well as the business needs of UMC. This is not currently taking place.

Core competencies of governmental entities usually do not include operation of an acute care hospital/health system. Competent and effective Governance and Management should be free to focus on developing a realistic Strategic Plan and, more importantly, relentlessly focusing on its implementation. Entities such as hospitals/health systems should not be required to use governmental systems which were not designed for such application.

We encourage the current bed configuration and product offerings at UMC focus on the needs of the community and crafting product offerings which meet those needs. An effective assessment and realistic strategic plan will provide guidance for the size of the Hospital and how the asset should be configured in the future.

Based on discussions with facilities and equipment personnel and management, and a tour of the facility, it appears that the core infrastructure of the Hospital is in good working order, and costly facility and bio-medical equipment, such as boilers, radiology equipment, elevators, and HVAC, are monitored under a combination of regularly scheduled maintenance performed internally, preventative maintenance contracts with third-parties, and manufacturers warranties. However, we recommend that UMC assess the physical building to determine if the current structure will support a transition from a "hospital centric" model to an "ambulatory and physician centric" model.

Strategic Options for Operations

There are several options to explore and, ultimately, a strategic plan must be developed for the option selected.

As strategic plans are formulated, the District and UMC governance and management will need to evaluate all necessary capital investment, including the aforementioned, to determine if the facility/structure in its current form meets the needs for transitioning from being "hospital centric" to "ambulatory and physician centric".

During the course of this transition, there are several options to explore and, ultimately, a strategic plan must be developed for the option selected. The District and UMC governance/management must decide on a long-term path toward a permanent solution.

Options include:

- Current State: Hospital Centric
- Ambulatory and Physician Centric
- Ambulatory and Physcian Centric Focus with Scaled Down Acute Inpatient Services

Depending on the option selected, there may be an opportunity to partner with existing organizations operating in the District, Virginia and Maryland market place to enhance the value proposition for the solution selected.

We believe an "Ambulatory and Physician Centric" focus with scaled down acute inpatient services may be the best option. It preserves inpatient services, albeit on a scaled back basis, and allows the transition to a campus focused on ambulatory and physician services. As community confidence grows in the quality and customer service levels the inpatient component can grow to an appropriate size.

In our experience, it is uncommon for such a transition to occur in three years or less. The success of a more aggressive timeline is highly dependent on prompt alignment of the following factors:

- Streamlined and effective Board of Directors
- Appropriate skill sets in the executive management suite
- Development of strategic and implementation plans with approvpriate performance metrics
- Physician integration
- Ensuring The Joint Commission accreditation
- Product lines that meet community needs, with tracking of goals and outcomes
- Compliance with regulatory environment, particularly Medicare and Medicaid
- Adequate internal controls to support accurate, timely, consistent and reliable financial reporting
- Billing practices that maximize reimbursement
- Sound IT infrastructure and management
- Physical facility that serves the needs of an "ambulatory and physician centric" focus

Strategic Options for Business Model

We were engaged to provide a review of the business model currently in place for UMC.

Business models describe how the pieces of a business fit together as a system to create value to the customers.

It may be counter-intuitive, but in our experience, for governmentally owned hospitals, the ownership and tax status of a hospital/health system are not the most important elements of a business model and in determining the long-term success of the organization.

Business Model definitions are plentiful and varied. For purposes of this report we used the following definition: "Business models describe how the pieces of a business fit together as a system to create value to the customers." We have developed, for a hospital, twelve variables which, when taken in totality, represent the elements of a successful business model. These include: 1) ownership 2) tax status 3) governance 4) management 5) outsourcing of clinical and operational departments vs. internal management 6) strategic plan 7) scope of services 8) market segments 9) geographic focus 10) payor sources 11) physician integration and/or alignment and 12) vertical and/or horizontal integration.

We reviewed business models of other governmental hospitals and health systems in the United States. Several have been clients served by consultants on The McGladrey Team. Within the last 18 months, several relevant and useful commissioned studies of governmentally owned hospital/health systems business models have been completed. It may be counter-intuitive, but in our experience, for governmentally

owned hospitals, the ownership and tax status of a hospital/health system are not the most important elements of a business model in determining the long-term success of the organization. We believe the most important factors and predictors of long-term institutional success are centered on:

- **Governance**
- **Management talent and their ability to implement strategy and tactics**
- **The degree of freedom from political influence and government policies and practices to allow the Board and Management to focus on the best interests of the organization**
- **Physician integration and/or alignment**

Critical to UMC's long-term viability is to adopt action plans which more completely address each of these factors. Action plans should be developed within the context of the community's and District's needs while utilizing the acumen associated with hospital and healthcare best practices.

Exhibit A profiles the current UMC business model, along with five additional options for the UMC Board, District Council and Mayor to consider.

Exhibit A profiles the current UMC business model, along with five additional options for the UMC Board, District Council and Mayor to consider. One option moves dramatically away from beds to ambulatory services. Another downsizes the Hospital in the short-term while changes in strategy unfold, then gradually re-opens beds as the community gains confidence in UMC and returns for care. Other options reflect a move from day-to-day control into lease or sale position. Each option has strengths and weaknesses. For example lease, sale or total facility management contract options will most likely find the operating party insisting the District serve as a deficit financier for some period of time until the transition model is sustainable. With each option, we have suggested a summary action plan for the next three years. It is the execution of the action plan that will be critical to long-term success. Our interviews with 49 area healthcare executives provides UMC with possible partnerships and relationships which, when fully vetted and structured properly, provides the opportunity to meet community needs and a sustainable business model that may lessen the negative financial impact on the District. There are success stories associated with these models around the country. In our opinion, execution of the selected business model is more important than the model itself and is the best predictor of long-term success.

Importance of Internal Controls

It is considered best practice to formally document policies, procedures and controls for all functions and transaction cycles critical to the financial reporting process.

Internal controls over financial reporting are critical to the overall success of any business model. Accurate, consistent, timely and reliable financial and non-financial information enables governance committees and management to evaluate the outcomes of a strategic initiative. In each area evaluated at UMC, we noted an absence or insufficient formal, documented, statements of operating procedures (SOP), especially related to the coordination between the OCFO employees, Hospital employees, and contractual employees. We did, however, observe some level of documented policies and procedures for certain functions, such as the Patient Financial Services (PFS) department. It is considered best practice to formally document policies, procedures and controls for all functions and transaction cycles critical to the financial reporting process. Such documentation provides clarity to employees related to their role and responsibilities, enables management to evaluate staff performance and process efficiency, and establish accountability, which collectively ensures accurate, consistent, timely and reliable financial reporting.

Over the past fiscal year, the Hospital has experienced a significant increase in patient accounts receivable and cash availability has become severly constrained. Proper design and operation of internal controls, among other factors, creates the foundation for monitoring financial performance and ensuring cash flows are adequate to support the Hospital's operations.

Over the past fiscal year, the Hospital has experienced a significant increase in patient accounts receivable and cash availability has become severly constrained. Proper design and operation of internal controls, among other factors, creates the foundation for monitoring financial performance and ensuring cash flows are adequate to support the Hospital's operations. Effective controls alert management of deficient processes and activities, such as high rates of claim denials, excessive uncollectible patient accounts receivable, and discrepancies with vendors.

Communications

UMC management is also responsible to ensure its IT Department has accurate maps, detailed directions, and, most importantly, that all teams are communicating and working together to reach common goals. The need for assurance about the value of IT, management of IT related risks and increased requirements for control over information are now understood as key elements of enterprise management. Business IT strategic alignment, IT value delivery, IT risks management, IT resource management and IT performance management, constitute the core of IT leadership and operations. It is the responsibility of management for leadership, and establishment of organizational structures and processes that will ensure UMC's IT sustains and extends the organization's strategy and objectives.

Information Security

By executive management stressing the importance of information security, a security mission can be establish within UMC, along with

established goals to fulfill such mission. Executive management should stress the importance of information security and emphasize the need to comply with HIPAA security, meaningful use, and other requirements. Such goals and outcomes are imperative to be eligible for incentive payments under the Patient Protection and Affordable Care Act related to electronic health records systems, which could be as great at $2 million.

Product Lines and Accountability

Management, the Board and UMC leadership and medical staff should be applauded,…the product line review detected management/executive initiative and effort toward establishing services that utilize the UMC facilities and/or meet certain of the identified healthcare needs of its community and constituents.

Management, the Board and UMC leadership and medical staff should be applauded, even with numerous challenges, including an unsettled ownership and operating environment for the past 10 years. The product line review detected management/executive initiative and effort toward establishing services that utilize the UMC facilities and/or meet certain of the identified healthcare needs of its community and constituents. These efforts are resulting in the beginning stages of improved services, clinical outcomes, customer service, and performance improvement.

Management is in the process of assessing the level of physician staffing and related compensation. The preliminary analysis reveals that revenue generated by UMC physicians is not sufficient to offset the total cost of physician compensation packages.

When these actions are quantified, management will be in a better position to determine whether the resulting level of subsidy is sustainable.

Management is in the process of assessing the level of physician staffing and related compensation. The preliminary analysis reveals that revenue generated by UMC physicians is not sufficient to offset the total cost of physician compensation packages. Further analysis is underway at UMC to determine the fiscal impact. Also, management is considering certain actions that it anticipates will mitigate the significant subsidy determined in the initial analysis, which is currently believed to be several million dollars. When these actions are quantified, management will be in a better position to determine whether the resulting level of subsidy is sustainable. Upon completion of this analysis, a process must be established whereby physician contracts are reviewed by legal counsel and finance personnel, then by the Board of Directors for final review and approval.

UMC product lines are largely consistent with the community needs identified by the Rand Study of 2008. Women and Infants Health, Pediatrics, Advanced Wound and Hyperbaric Medicine, Infectious Disease, Minimally Invasive Vascular services and Diabetes and Obesity are direct responses to the community needs identified in the Rand Study. Behavioral Health, to a lesser extent and the SNF to a greater extent, appear to have been established to absorb excess capacity at the UMC facility.

UMC is structured as a traditional acute care hospital. The organizational chart and management accountabilities are centered on departmental accountabilities rather than product lines. The financial reporting and operating management tools are not designed to support product line operations or clinical and management accountability. Therefore, our ability to assess product line viability was severely

The financial reporting and operating management tools are not designed to support product line operations or clinical and management accountability. Therefore, our ability to assess product line viability was severely hampered.

We recommend UMC management evaluate such out-sourced arrangements to ensure they create a win-win relationship under the "ambulatory and physician centric" focus.

…there are a number of health conditions is Wards 7 and 8 which may justify the creation of new product lines, or the expansion of current product lines….

hampered. A commitment to manage operations by product lines will be necessary to increase the likelihood of improved clinical outcomes, customer service and organizational success over the long run.

Several product lines appear to be more conceptual than a reality due to a combination of a short life cycle and inadequate systems, structures and processes to support their development. Our observations regarding the product lines reviewed are summarized in Exhibit B. Some product lines are out-sourced under arrangements which do not appear to be financially viable and supportive of UMC re-establishing its own primary care medical community (Pediatrics ED and Women's Health). We recommend UMC management evaluate such out-sourced arrangements to ensure they create a win-win relationship under the "ambulatory and physician centric" focus.

Finally, there are a number of health conditions in Wards 7 and 8 which may justify the creation of new product lines, or the expansion of current product lines to address the health conditions of the community, including asthma, heart disease, cardiovascular disease and ophthalmology.

As set forth in our Business Model Assessment, we recommend UMC be more "ambulatory and physician centric" in the near and long-term to provide the best opportunity for the organization to stabilize in the short-term and become a financially viable organization that can sustain itself over the long-term.

Skilled Nursing Facility (SNF)

Due to differences in regulations, clinical care models, service billing, and Resident and family wants and expectations, the keys to operating a successful SNF are unique, and can vary significantly from the traditional hospital environment. Through our assessment, we identified certain quality of life and regulatory and financial matters for UMC to consider. Unlike a short stay hospital environment, many residents of a SNF are there for an extended period of time. Therefore, regulations and resident wants and expectations require, at a minimum, a satisfactory quality of life. In addition, the regulatory and financial environment can be complex and oversight from regulatory agencies can be strict. Establishing a true 'home' environment, providing age and condition appropriate activities, and ensuring care provided is necessary and supported, amongst other factors, are critical to the overall sustainability of the SNF operations.

Accreditation Review

Our assessment included 18 chapters of TJC standards or elements of performance, selected generally because they are "direct impact", had been cited on a recent TJC survey at UMC, and/or are commonly problematic/likely to be cited during an actual TJC survey.

As part of our engagement, we performed a "high level" assessment of compliance with The Joint Commission (TJC) standards. From August 22 through 26, 2011 we performed an on-site regulatory and accreditation assessment. Hospital leadership and staff members are to be commended for their cooperation and receptivity during the review process. Our assessment included 18 chapters of TJC standards or elements of performance, selected generally because they are "direct impact", had been cited on a recent TJC survey at UMC, and/or are commonly problematic/likely to be cited during an actual TJC survey. The following table provides a dashboard summary of the results of our assessment:

Chapter:	
Accreditation Participation Requirements	Red
Environment of Care	Red
Emergency Management	Yellow
Human Resources	Yellow
Infection Prevention and Control	Yellow
Information Management	Yellow
Leadership	Yellow
Life Safety Code	Red
Medical Staff	Yellow
Medication Management	Yellow
National Patient Safety Goals	Yellow
Nursing	Yellow
Provision of Care, Treatment and Service	Yellow
Performance Improvement	Yellow
Record of Care, Treatment and Service	Yellow
Rights and Responsibilities of the Individual	Green
Transplant Safety	Green
Waived Testing	Green

This assessment, while reflecting significant challenges on its face, does not imply that UMC will not have a successful Joint Commission Survey.

This assessment, while reflecting significant challenges on its face, does not imply that UMC will not have a successful Joint Commission Survey. Rather it points out areas which deserve immediate administrative and clinical leadership attention, given the fact that TJC can appear at any time for the triennial survey.

Medicare and Medicaid

Our engagement also included assessments of certain aspects of the Medicare and DC Medicaid programs and the related impact on UMC.

Regarding the District's State Plan Amendment (SPA), we estimated the increase/decrease in DC Medicaid rates paid to UMC as a result of the change in prospective payment methodology. It is estimated that the increase in annual DC Medicaid rates due to the implementation of APDRG grouper version 26 and the new base rate will be approximately $2.6 million. UMC's APDRG base rate and the other District hospitals' base rates appear to be calculated in accordance with the SPA, with certain exceptions.

On July 9, 2010, the District foreclosed on UMC for non-payment of loans owed to the District and acquired UMC. Simultaneously, the District contributed the foreclosed assets and assumed liabilities to the Not-for-Profit Hospital Corporation. When a hospital undergoes a change of ownership ("CHOW") of this type, a termination cost report is required to be filed. We verified with Highmark Medicare Services (Highmark), the Fiscal Intermediary/MAC (FI/MAC), that no termination cost report was filed for the January 1, 2010 through July 8, 2010 period. Further, it was verified with Highmark that no request has been made to change the cost reporting year end from December 31 to September 30, the accounting year end for the Not-for-Profit Hospital Corporation.

We also noted the Medicare cost report reflects that a Medicaid fraction of 34.93% was used in the DSH calculation. According to the independent consultant who prepares the cost report, the patient specific DSH listing to support the fraction was not provided because it was never prepared. As a result, an alternate method was used to calculate the Medicaid fraction. The Hospital received approximately $3.3 million in Medicare operating DSH payments related to the fiscal year ended December 31, 2010. We determined UMC has not properly reported the Medicaid fraction in the DSH calculation. Further work will need to be performed to determine the increase or decrease in Medicare DSH payments.

For fiscal year 2011, UMC received $14.9 million in Medicaid DSH payments. We performed procedures to determine if any portion of the payments will be retrospectively disallowed. We determined the data included in the DSH data collection tool, which was developed by DHCF, does not appear to be accurately reported. This is an error in

the calculation of the ratio of cost to charges. All other factors remaining the same, the recalculation of the DSH data using a proper cost to charge ratio, based on the Medicare cost report, would reduce the DSH payment from $14.9 to an estimated $13.2 million, using the 2010 tool for the fourth quarter only, and an estimated $11.2 million, if the revised 2010 tool were used for the entire fiscal year 2011.

Chapter 1: UMC Business Model Assessment

Summary

UMC has had a turbulent history for over a decade.

UMC has had a turbulent history for over a decade. Originally known as Greater Southeast Community Hospital, UMC has experienced bankruptcies and ownership, governance and executive management changes. It is noteworthy that the Hospital's staff and its loyal physicians have been able to overcome such turbulence. Metaphorically, visualizing the organization as a clothes washing machine, UMC has been stuck on the agitation cycle for a long time. If the communities of Wards 7 and 8 are to be appropriately served in the future, it is necessary for more consistency and less disruption; the organization must narrow its focus by concentrating on the community needs. Filling a hospital, whose size (beds) is not consistent with community needs, will not meet the health care demands of 2011 and beyond.

Metaphorically, visualizing the organization as a clothes washing machine, UMC has been stuck on the agitation cycle for a long time.

With the exception of hospitals that have developed a respected and unique set of clinical programs which draw patients from locations well beyond their primary and secondary catchment areas, most hospitals serve as a mirror, simply reflecting back the makeup of the communities they serve. As the community has changed over the past twenty years, so has UMC, reflecting the changes in the community. As the demographics changed and the payor sources changed, moving toward governmental payors, UMC found itself in a steady, downward operating and financial performance spiral, and the reputation of the Hospital and the medical community followed closely behind.

Trends and Issues

The Rand Community Needs Study (Rand Report) published in January of 2008 is comprehensive and well done. It was beyond the scope of our engagement to update this study and therefore we welcomed the results of the Rand Report and have accepted its validity even though the study is four years old.

The Rand Report highlighted several trends and disturbing issues including individual health status, use of health care services and access to health care providers for Wards 7 and 8. These include the high prevalence of chronic disease (10% asthma, 8% diabetes, 5% heart disease, 3% cardiovascular disease, over 50% overweight and obese and greater than 25% obese.) The Rand Report reveals Wards 7 and 8 generally have higher rates of chronic disease, poor health status and premature mortality. Ward 7 had the highest rate of asthma (18%) of all Wards in the District. In spite of high rates of insurance coverage, attributed to Medicaid and the Alliance program, 20% of

When people of all ages access the health care system in Wards 7 and 8, they do so inappropriately because they enter the system through emergency departments and specialists rather than primary care sites. The Rand Report observed rising inpatient admissions for ambulatory sensitive conditions and suggests worsening access to non-hospital based care in recent years.

The Rand Report indicates patients with acute problems such as heart conditions, strokes and major trauma are sometimes transported to hospitals that are not best suited to meet their needs. As noted in the report, this is a particular problem for residents in Wards 7 and 8 transported to UMC.

The very presence of inpatient beds residing in Wards 7 and 8 serves as a distraction, which causes well meaning people to direct limited resources to maintaining a facility which is not designed to meet the needs of the population.

District residents reported no consistent source of care. This appears to be the case for Wards 7 and 8. With over 90% of children in Wards 7 and 8 having public or private insurance there is an expectation there would be good access to medical providers. This is not necessarily the case. When people of all ages access the health care system in Wards 7 and 8, they do so inappropriately because they enter the system through emergency departments and specialists rather than primary care sites. The Rand Report observed rising inpatient admissions for ambulatory sensitive conditions and suggests worsening access to non-hospital based care in recent years. Meaning, many inpatient admissions are for conditions which, if addressed early and in an ambulatory setting, could be avoided. The relevant fact is admissions for ambulatory case sensitive conditions were highest in 2006 among adults in Wards 7 and 8. The Rand Report also indicates that Emergency Department (ED) encounters which are primary care sensitive have risen for adults between the ages of 18-64. This means many ED visits could and should be handled in a primary care office at much less cost to the system rather than an expensive ED setting. Children in Wards 7 and 8 are likely to have a low probability of having a “well child” visit or regular dental care. Finally, the Rand Report indicates patients with acute problems such as heart conditions, strokes and major trauma are sometimes transported to hospitals that are not best suited to meet their needs. As noted in the report, this is a particular problem for residents in Wards 7 and 8 transported to UMC.

A careful reading of the Rand Report for 2007 and 2008 indicates a hospital centric approach to delivering cost effective healthcare services for Wards 7 and 8 is not meeting the critical needs of the community. We believe a greater emphasis on an ambulatory and physician centric approach would be more effective and efficient way to deliver care. There are 354 licensed beds (234 acute, 120 skilled nursing) in Wards 7 and 8, all located at UMC. The very presence of so many beds serves as a distraction, which causes well meaning people to direct limited resources to maintaining a facility which is not designed to meet the needs of the population.

While the current ownership is governmental, this model is less than one year old. Prior for-profit ownership was focused on a return on investment to meet shareholder investment expectations. Governmental ownership has different motivations and return on investment expectations than for profit organizations, and therefore, less pressure to produce short-term profits. This may provide the District and its leadership the opportunity to refocus the organization and, in doing so, meet the health needs of the communities in Wards 7 and 8. The foreclosure of UMC by the District in July of 2010 may have achieved certain public policy needs, however, in many respects, the foreclosure and assumption of ownership of UMC made it a

We believe the transformation of UMC results in an organization that does not require an on-going subsidy, including UMC's physicians, and the Hospital will become an attractive acquisition target to an outside party resulting in the sale or lease of UMC's assets and liabilities to a long-term owner/manager.

"reluctant" governmental hospital. It is in the best interest of the District and the community to determine the appropriate business model which will allow the organization to meet the needs of the community, and do so in a way which will allow UMC to improve performance and be sustainable over the long-term. We believe the transformation of UMC results in an organization that does not require on-going subsidy, including UMC's physicians, and the Hospital will become an attractive acquisition target to an outside party resulting in the sale or lease of UMC's assets and liabilities to a long-term owner/manager.

As mentioned in the Rand Report, a majority of UMC hospital patients are District residents. At most other District hospitals, patient origin is more mixed. Given UMC's location on the border of Prince George's County, Maryland, this would seem to be an opportunity for enhanced operational performance and to broaden the patient mix to include more local residents. Determining whether it is appropriate for UMC to embrace Maryland communities' healthcare needs should be strategically addressed. The ramifications of limiting UMC's strategic thinking to District residents are significant. Focusing on Maryland markets, even though not part of the District, allows UMC to better meet the needs of the District and Wards 7 and 8 by expanding its volumes. A service-oriented approach would find the Board and Management working through the issues to provide Maryland residents viable access to the UMC medical community.

Governance

The members interviewed expressed a need to increase overall Board performance. They described the Board as not working effectively and getting involved in operations rather than focusing on strategy, governance, policy and accountability.

We recommend an assessment of the Board of Directors from a system, structure and process perspectives.

Governance was not the major focus of this engagement, however, the individual interviews with the majority of UMC Board members yielded information which is germane to our report and findings and we believe, important to the success of the organization. The members interviewed expressed a need to increase overall Board performance. They described the Board as not working effectively and getting involved in operations rather than focusing on strategy, governance, policy and accountability. Additionally, a number of Board members felt there was too much political influence making it difficult to make decisions in the best interest of the Hospital and the communities served. Board Committees are just now being created and populated by Board members after almost ten months of Board existence. There are a number of open issues causing friction between the Medical Staff leadership and the Board over the lack of full participation on the Board by the elected leaders of the organized Medical Staff. The future success of UMC is tied directly to the transformation of the medical community; therefore, these differences need to be resolved, both for practical/strategic reasons as well as for TJC standard compliance. We recommend an assessment of the Board of Directors from a system, structure and process perspectives.

Quality care and the ability to prove UMC quality is the pathway to sustainability. Quality care needs to move to the top of the list of HIGH PRIORITY items for the Board and Management.

Our counsel is that the quality of the relationship between the OCFO, the UMC Board, and most importantly the CEO of UMC, is critical for UMC's success, not the structure itself. All parties involved should focus on building a trusting and productive relationship so all parties can carry out their responsibilities

"Best in class" strategic plans incorporate the values of the organization into the strategy. Values anchor the culture.

Once the assessment is completed and recommendations are considered and adopted, the Board, along with management and the Medical Staff, will benefit from building an actionable strategic plan and adoption of measurable performance metrics which track the performance of accountable parties for implementation of short- and long-term goals and objectives. Many Board members interviewed voiced concern about the lack of understanding they possess of the quality of care delivered at UMC. Quality care and the ability to prove UMC quality is the pathway to sustainability. Quality care needs to move to the top of the list of HIGH PRIORITY items for the Board and Management. The final area which has consumed Board energy is the role of the Office of the Chief Financial Officer for the District of Columbia (OCFO), and the implications for the Board and its fiduciary duty to oversee the financial operations of UMC. Our counsel is that the quality of the relationship between the OCFO, the UMC Board, and most importantly the CEO of UMC, is critical for UMC's success, not the structure itself. All parties involved should focus on building a trusting and productive relationship so all parties can carry out their responsibilities.

Management Talent and Implementation of the Strategic Plan

Since the Board has not adopted a strategic plan the Board and Management do not have a solid foundation and "road map" to evaluate management performance and recommendations or assess opportunities which present themselves from outside parties. A well crafted strategic plan is grounded in the Mission, Vision and Values of the organization. "Best in class" strategic plans incorporate the values of the organization into the strategy. Values anchor the culture. The majority of strategies, mergers and acquisitions that fail, do so over the lack of attention to the role of culture. Our interviews touched on the profound change in culture that is necessary when there is a change of ownership. With the history of change at UMC, and as the organization moved from a for-profit owner to a non-profit it also became part of a governmental entity with sunshine laws, procurement and human resource policies, politics and bureaucracy. It is not clear how the Board, Management or the District incorporated these changes into governance, strategy, operations and policy.

Several high profile joint ventures have created high expectations for increased volume and a "halo effect" by partnering with well respected hospitals and health systems operating in the District. These joint ventures are consistent with the Rand Report. However, there is no convincing evidence that UMC has benefited significantly from the relationships. Based upon multiple interviews, one of the joint ventures may have resulted in a significant increase in operating costs and no new admissions to UMC. We believe the goal must be to meet community needs and in a way that the organization benefits from the

relationship financially and with image and brand enhancement in the eyes of the community.

An observation made by us is Management has a number of good ideas and a passion to do the right things. However, we were not provided with a comprehensive analysis measuring the level of success in implementing these ideas. In our view, the organization will be best served if 1) a strategic plan is developed, reviewed and adopted by the Board of Directors 2) quality care is emphasized and elevated to the HIGHEST priority by the Board of Directors, 3) capital and operating plans reflect implementation of the strategic plan, 4) the Medical Staff manpower plan is viewed as equal in importance with the Strategic Plan and is in fact embedded in the strategic plan, and 5) the Board of Directors holds management accountable for implementation of the strategic plan and achieving the financial objectives agreed in the annual budget.

Based upon our experience there are tested and proven leadership attributes, competencies and areas of focus necessary in the executive management suite to undertake the implementation of our recommendations.

Such a transition, especially as it involves a safety net hospital, requires a unique set of management competency. Safety net hospitals are highly susceptible to volatility, often plagued with limited cash, older physical plants, poor payor mix, dated clinical and administrative technology, aging medical staffs with limited numbers within each specialty, poor community reputations and leadership which is both limited in numbers and quality.

Based on our experience, the following leadership attributes, competencies and areas of focus are necessary in the executive management suite to undertake the implementation of our recommendations:

Leadership attributes:

- A sense of urgency without creating panic in the organization
- Effective decision making without perfect information
- A commitment to results and respect rather than being liked
- Willing to right size the organization while having compassion for employees impacted by these decisions
- Straight forward, transparent, timely and frequent communications to key stakeholders which leads to no surprises
- Seek to have proud employees rather than happy employees
- Hold people accountable for performance
- Embrace and leverage physician leadership in the C-Suite

Competencies:

- A relentless passion for operations to include the efficient movement of patients through the hospital and the elimination of "work-arounds"
- Performance improvement skills
- Evidence based decision making to include financials, volume, clinical quality, customer service, market share, productivity, benchmarks, etc.
- Development of goals, objectives, timelines, accountabilities and monthly dash boards which track performance
- Obsession about customer service
- A willing and capable partner externally and internally
- Areas of Focus:
    - Span of control for management and a flat organization chart
    - Full time equivalents per adjusted occupied bed
    - Preservation of cash
    - Revenue Cycle
    - Win-Win Partnerships
    - Physician recruitment and retention
    - Primary care base
    - Supply chain

It is very uncommon for leaders to possess the required skill sets for all phases of an organizations life cycle.

We believe an important responsibility for Governance is to determine the necessary skill sets required to operate UMC, compare those against the skill sets of the current leaders in the C-suite and determine necessary actions where there are gaps. Governance should consider the changing skill set requirements as the institution emerges from its current challenges and enters the next phase of its life cycle. It is very uncommon for leaders to possess the required skill sets for all phases of an organizations life cycle. It is not uncommon and quite normal for the leadership team to make difficult decisions and choices during tough economic times that may not be required over the longer term and, in fact, may make it difficult to be effective as the organization moves beyond the transition phase.

Good Politics and Fiduciary Duties

Over the past decade a number of governmental hospitals undertook restructuring to allow the hospital/health system to move quickly and effectively in the rapidly changing healthcare market place. In addition, they sought to distance the healthcare organization from the politics and bureaucracy of the governmental owner. We have observed in

some instances hospitals have become homes for patronage jobs of elected officials. Some governmental owners have not trusted the hospital leadership to control expenses and comply with their contracting and minority hiring policies and, therefore, subject the hospital to the same set of procurement, revenue cycle, human resources and financial systems which work for a traditional governmental agency but do not necessarily work effectively for a hospital/health system.

We suggest the Board of Directors and management of UMC be held accountable. If governance and leadership do not achieve defined and agreed upon goals, objectives and performance metrics, then it will be the responsibility of the District leadership to take corrective action.

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We suggest a structure and processes be developed to review the budget versus actual performance on a regular basis, and to track the implementation progress of our recommendations. Additionally, we encourage regular meetings between the Mayor's staff and other District staff and Governance and management.

We believe it is important for UMC to be insulated from unnecessary political influence and bureaucracy to enable UMC to accelerate performance and results for the people of Wards 7 and 8.

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Physician Integration and/or Alignment

Our interviews and review of documents yielded 39 primary care physicians whose principle practice is located within Wards 7 and 8. The Kaiser Family Foundation estimates that the primary care to population ratio is 1:2000. Using this ratio, Wards 7 and 8 would require at least 70 primary care physicians.

It is our experience that a best practice for success in present-day healthcare systems for institutions like UMC lies in the success of its medical community. We have seen many successful medical communities with failing hospitals; however, we have not seen successful hospitals without successful medical communities. Our interviews and review of documents yielded 39 primary care physicians whose principle practice is located within Wards 7 and 8. The Kaiser Family Foundation estimates that the primary care to population ratio is 1:2000. Using this ratio, Wards 7 and 8 would require at least 70 primary care physicians. Surgeons and medical sub-specialists will not locate in communities where there is not a strong primary care base. The Medical Staff Plan developed for UMC by RAFrank Associates in May 2009, provides a current assessment of the medical community and forecasts, by specialty, the needs of the community. This study confirms our belief that the medical staff by specialty is aging and there is little depth in virtually all specialties. As noted elsewhere in this report, the payor mix makes it very difficult to recruit and retain physicians. RAFrank Associates concurs with us that a partnership with a Federally Qualified Health Center (FQHC) is a cost effective way to build up the primary care base and provides the foundation for the recruitment of other specialties.

Safety net hospitals and the underlying community medical practices usually find the payor mix a significant disadvantage and very difficult to overcome financially. This burden leads to a gradual erosion of the quality and quantity of the medical community. It becomes very difficult to recruit additional or replacement physicians. As a result, the medical community ages and retires without an appropriate succession plan. Our experience finds the most efficient and effective way to undertake the reinvention of a safety net hospital's primary care medical community is to create a FQHC on their own, or partner with a FQHC already operating in the marketplace that has the experience and infrastructure to employ physicians and other professional staff. Due to the favorable reimbursement and funding to supply support services, primary care physicians are attracted to these communities and establish viable practices that serve as the foundation to grow medical sub-specialties and surgical specialties. It is our experience that people largely select physicians and not hospitals. If a viable medical community is attracting and retaining patients, the remaining services provided by UMC become more viable.

If a viable medical community is attracting and retaining patients, the remaining services provided by UMC become more viable.

Acute Care Beds in Wards 7 and 8 - Moving from Hospital Centric to Ambulatory and Physician Centric

In our experience the actual need for acute care beds in a community is quite emotional but may not be fiscally sound. Primarily due to the rapid change in technology traditional inpatient care can convert to ambulatory care, length of stays are shorter, and reimbursement levels for hospitals are lower, forcing a significant number of hospitals to restructure and many close. Commonly, the traditional inpatient hospital model had been replaced by a robust ambulatory care model.

In our experience the actual need for acute care beds in a community is quite emotional but may not be fiscally sound.

Wards 7 and 8 have a population of approximately 140,000. There is a need for acute care in these Wards. According to the Kaiser Family Foundation report on health care in the United States published in 2011, using data from 2009, the District has the highest bed per 1,000 population ratio in the nation at 5.8 beds, or a total of 3,439 beds based upon a District population of 593,000. The national average is 2.6 beds per 1,000 population. If the national average was achieved by the District there would be 1,542 beds. It is recognized that several District hospitals draw from very large catchment areas whose populations reside outside of the District. In addition, earlier in the decade UMC lost its Joint Commission Accreditation. During that time UMC inpatient activity essentially ceased. The healthcare leadership in the District indicated UMC patients were largely absorbed by existing hospitals without much difficulty during this lapse in inpatient care at UMC.

In four of the eleven zip codes in Wards 7 and 8 there were no Medicare admissions in calendar year 2010.

Market share is normally viewed as the leading indicator of a community's perception of an institution.

Many residents of Wards 7 and 8 have selected acute care facilities other than UMC. Using Medicare market share for the calendar year 2010 as a proxy, UMC's overall market share in Wards 7 and 8 (in the eleven zip codes present in these two Wards) ranges from 0% to 23.9%. In four of the eleven zip codes in Wards 7 and 8 there were no Medicare admissions in calendar year 2010. Market share is normally viewed as the leading indicator of a community's perception of an institution. The Press Ganey patient satisfaction scores indicate significant dissatisfaction with customer service at UMC. The lack of physician specialties and primary care physicians, patient dissatisfaction, and the reputation of the quality of care in the community lead to an underutilized facility.

As detailed in Option 2 of Exhibit A, based on the national average of 2.6 beds per 1,000 population and market share ranging from 0% to 23.9%, we believe 60 medical-surgical beds would be adequate upon the initial shift in focus to "ambulatory and physician centric". In addition to these beds, there would be an intensive care unit (16 beds), behavioral health beds (34 beds), an OB unit (15 beds) and a nursery (24 beds). Part of the medical-surgical beds would be the introduction of some level of observation beds. The SNF units would be evaluated and possibly closed at some point in the near term. The Behavioral Health program also requires a full review on the inpatient side of service.

We suggest the focus for Wards 7 and 8 primarily be on meeting the needs of the community with less emphasis on utilization of the current facility.

Hospitals are no longer the center of healthcare delivery.

Any move toward an ambulatory centric model for Wards 7 and 8 has significant issues that will require attention and resolution. There are political, care giver, and community challenges, as well as relationships with other hospitals in the region. The Rand Report highlights the chronic disease problems, inappropriate use of inpatient and ED services and lack of accessing the healthcare system prevalent which are present in Wards 7 and 8. We suggest the focus for Wards 7 and 8 primarily be on meeting the needs of the community with less emphasis on utilization of the current facility. The current hospital was built in an era when the healthcare system was hospital centric. Hospitals are no longer the center of healthcare delivery. UMC needs to evaluate options for the hospital facility and consider more emphasis on an ambulatory and physician centric model to meet the pressing needs of the communities served.

We believe it is important to separate SNF services strategies from other primary and acute hospital services.

SNF beds at UMC require further discussion. While SNF services provide a seemingly good use for the presently under-utilized facility, there are different clinical and operational drivers to these lines of service. More importantly, they are not critical for the medical delivery system required to meet the primary care needs of the community. We believe it is important to separate SNF services strategies from other primary and acute hospital services. These services should be addressed outside the context of how to utilize an under-utilized acute care hospital. In addition, there are unique and complex challenges

with the District's prisoner unit. A thorough review should be performed for the impact and perceptions associated with the SNF and prisoner unit.

Chapter 2: Product Line Reviews

Management, the Board and UMC leadership and medical staff should be applauded, even with numerous challenges, including an unsettled ownership and operating environment for the past 10 years. The product line review detected management/ executive initiative and effort toward establishing services that utilize the UMC facilities and/or meet certain of the identified healthcare needs of its community and constituents.

Summary

Management, the Board and UMC leadership and medical staff should be applauded, even with numerous challenges, including an unsettled ownership and operating environment for the past 10 years. The product line review detected management/executive initiative and effort toward establishing services that utilize the UMC facilities and/or meet certain of the identified healthcare needs of its community and constituents. These efforts are resulting in the beginning stages of improved services, clinical outcomes, customer service, and performance improvement.

The risk of these efforts being unsuccessful over the long-term can be significantly reduced if a consistent approach to planning, presenting, approving (if appropriate) and implementing major business endeavors, such as product line initiatives, is made a leadership imperative. This process forms the basis for effective communication and transparency among all stakeholders. With the absence of this process, it becomes difficult to obtain consistent and reliable product line information. Board members, medical staff, management, employed staff and community members will have the potential of common understanding of the strategic directions of UMC and the actions being taken to accomplish that end. It also helps ensure accountabilities are understood by all involved.

Leadership is to be commended on these initial steps to provide product lines which are responsive to community needs

To this end, it is difficult to speak to the long-term viability of any product line without this planning context. Analysis can only be made within an isolated context of individual identified community need or leadership initiative. Although there may be value within the isolated context, the initiatives do not add up to a viable medical enterprise when considered in the aggregate. The composite risks of the current set of product offerings combines to be less than the sum of its parts. Given the changing landscape of healthcare financing, this risk should and must be lessened.

There are a number of chronic health areas which are identified in the Rand Report which have not been addressed in the form of a Product Line. These include asthma, cardiovascular and heart disease.

We have been asked to comment on possible new Product Lines which may be considered by UMC. Leadership is to be commended on these initial steps to provide product lines which are responsive to community needs. There are a number of chronic health areas which are identified in the Rand Report which have not been addressed in the form of a Product Line. These include asthma, cardiovascular and heart disease. Typically, ophthalmology clinics are found in communities which have high levels of diabetes. These chronic health conditions are usually addressed on an ambulatory basis and may

result in the need for inpatient interventions in a certain percentage of the population. The addition of these product offerings is consistent with the recommended movement in the direction of becoming more "ambulatory and physician centric".

Many of our observations and the need for corrective action can be traced to significant turnover of key management and operational personnel.

There are certain findings that are applicable to all product lines. Many of our observations and the need for corrective action can be traced to significant turnover of key management and operational personnel. There are instances of discernible momentum toward making product lines functional and vital. However, there are areas presented as product lines that have not developed beyond the "to-be-formed" stage. The findings below apply to all product lines:

Attention to Community Needs

The needs of the community are reflected in virtually each product line.

The needs of the community are reflected in virtually each product line. There is consistency with the designated product lines and the findings of the Rand Community Needs Assessment, as well as a discernible orientation to meet the responsibility of the unique care needs of Wards 7 and 8.

Planning Document

In most instances, a product line's plan was articulated verbally. Supporting written documentation often consist of a contract, proposal presentation or capability credentials. When requested, summary statements were developed to support this review process, rather than prepared and available upon request. A consistent process needs to be developed and implemented to ensure a product line has an agreed-upon business plan, with goals and metrics stated in areas such as clinical measures, financial return expectations and ROI defined, and short- and long-term actions to achieve the strategic plan articulated. Some of the many benefits from a defined process include providing needed information to improve Board awareness and oversight, resource allocation and budgetary decisions, partner/vendor selection processes, and consistent communications to stakeholders (e.g., medical staff, community, management, Board of Directors, employees and District leadership). It also serves as an ongoing accountability document to assist in determining the need for the inevitable "course correction" actions.

Product Line Clinical vs. Financial Management

While reasonable clinical performance measures and awareness were observed, basic financial metrics and performance measures and management accountabilities were not so evident.

While reasonable clinical performance measures and awareness were observed, basic financial metrics and performance measures and management accountabilities were not so evident. This can be attributed to many factors, not the least being the turnover of key accounting personnel in 2010. An action plan to develop the capability to provide management with these tools and education to properly utilize them should be a high priority in the next few yearly planning cycles. This is not a recommendation to implement a sophisticated cost accounting system at this time. To be specific, it is aimed at

ensuring management has direct cost information and "real cash" revenue results of their service provision.

Performance Improvement/Six Sigma – Although the work of the Performance Improvement Committee is in its early stages, there is evidence of initiatives in each product line that is providing services within the UMC structure. Many of the initiatives are aimed at customer satisfaction improvement which is an important orientation for business growth. While customer satisfaction is important, it is often times confused with improved clinical outcomes which MUST be the focus of the organization. Given the path of healthcare reform, efforts to re-engineer clinical processes to strip out unnecessary costs and improving the movement of patients through the hospital should be high priorities for clinical and organizational leadership.

Market Share

While customer satisfaction is important, it is often times confused with improved clinical outcomes which MUST be the focus of the organization.

Given the disruptive nature of the past two years, tracking market share by product line may be somewhat misleading. In addition, most of the product lines are aimed at growing non-inpatient acute business, where market share information is not available. More important in these instances is monitoring short-term volume trends.

These comments can be addressed by developing institution-wide management processes and disciplines designed specifically to enhance the performance of each product line. Care should be taken to ensure that the task of implementing consistent strategic and management processes is accomplished.

Physician Staffing and Compensation

The preliminary analysis reveals that revenue generated by UMC physicians is not sufficient to offset the total cost of physician compensation packages.

This analysis was initiated to indentify opportunity for cost savings and/or revenue enhancement, in relation to physician compensation.

Over the course of the past few weeks, management has undertaken a review of physician compensation. The preliminary analysis reveals that revenue generated by UMC physicians is not sufficient to offset the total cost of physician compensation packages. The subject matter of the review relates to services rendered by physicians for the delivery of care, as opposed to administrative services. This analysis was initiated to identify opportunity for cost savings and/or revenue enhancement, in relation to physician compensation**.**

The purpose for various physician compensation arrangements at UMC fall into the following categories:

- On-call services for emergency coverage
- Subsidy to stabilize physician staffing of core services
- Recruitment tool for physicians, given UMC's challenging payor mix

The analysis we reviewed was in its infancy stage. Further analysis is ongoing by management. Management intends to expand the analysis to incorporate hospital volumes supported by such physician arrangements.

Enhance billing practices and procedures for physician services rendered as a part of these arrangements.

Modify contracts with physicians and/or physician groups to shift billing/collection responsibility to the physicians.

Reset physician staffing levels based on current volumes.

Determine whether physicians are billing under their own provider number and either move these billings back to UMC or adjust the compensation accordingly.

…a process must be established whereby physician contracts are reviewed by legal counsel and finance personnel, then by the Board of Directors for final review and approval.

There are certain actions management anticipates will mitigate the significant subsidy determined in the initial analysis, which is currently believed to be several million dollars.

- Enhance billing practices and procedures for physician services rendered as a part of these arrangements. This would be done in concert with other billing/collection endeavors underway at UMC. Management believes the collection performance experienced for professional billing is worse than that experienced for hospital services.
- Modify contracts with physicians and/or physician groups to shift billing/collection responsibility to the physicians. As a result, these physicians would have direct incentive to improve medical oversight and documentation associated with an optimally-functioning billing process.
- Contract with a third-party who would be responsible for all aspects of a clinical discipline, including clinical management and business operations. This is the case with behavioral health, where an RFP has been issued to manage many aspects of the discipline, including physician professional services.
- Reset physician staffing levels based on current volumes.
- Determine whether physicians are billing under their own provider number and either move these billings to UMC or adjust the compensation accordingly.

When these actions are quantified, management will be in a better position to determine whether the resulting level of subsidy is sustainable. Upon completion of this analysis, a process must be established whereby physician contracts are reviewed by legal counsel and finance personnel, then by the Board of Directors for final review and approval.

Current State of UMC Product Lines

In conjunction with our review, eight product lines were presented by leadership as areas of emphasis for UMC going forward as a standalone not-for-profit entity. The product lines presented are:

- Women and Infants Services
- Pediatrics
- Advanced Wound and Hyperbaric Medicine
- Center for Management of Infectious Diseases
- Minimally Invasive Vascular Services
- Center for Diabetes and Obesity

- Center for Behavioral Health
- Skilled Nursing Facility

Additionally, we reviewed Emergency Services and Radiology, because of the critical impact on both the support of the product lines mentioned above and the role as drivers of services generally required of a viable medical community.

Our recommendations for the Hospital are as follows:

- Evaluate the rationale for operating a SNF within the Hospital and determine whether it is a viable and necessary product line.
- For all other product lines mentioned above, make a strategic commitment to the successful implementation of the product lines and establish financial reporting and operating management tools that are designed to support product line operations and clinical and management accountability.
- Evaluate out-sourced arrangements to ensure they create a win-win relationship under the “ambulatory and physician centric” focus, such as Pediatrics ED and Women’s Health.
- Continue to evaluate physician arrangements to ensure the number of physicians and compensation levels align with an “ambulatory and physician centric” focus.

Product Line Reviews

Women and Infants Services

Based on data submitted, Wards 7 and 8 have the potential for 2,500 deliveries a year. For the 12 month period ending June 2011, UMC experienced 417 deliveries. Trends in deliveries since the beginning of 2010 are:

	Deliveries
January to June 2010	203
July to December, 2010	165
January to June, 2011	252

Volumes for the first six months of 2011 suggest a market share in Wards 7 and 8 to be approaching 20%. It had been anticipated that through a partnership with Washington Hospital Center (WHC), Unity Health (an established FQHC serving WHC’s and UMC’s communities) and Chartered Health, UMC would be able to grow beyond the levels above. The arrangement with WHC carries an annual cost of over $1.8 million, which includes $900,000 for malpractice insurance costs.

During our time on-site at UMC in August and September 2011, we inquired of UMC personnel directly responsible for the oversight of the Women and Infants Services department. Based on our discussions and reports provided, we were informed that no new deliveries could be directly attributed to this partnership and investment. We were also

informed, through June 2011, seven deliveries were accomplished by contracted WHC staff, which was a result of being on-call at UMC, rather than a result of a new referral.

Representatives from WHC, along with UMC management, subsequently provided us with an updated analysis of the outcomes of this partnership through November 2011. The report indicates from April 2011 through November 2011, 24% or 83 referrals for delivery can be attributed to this partnership and investment. UMC management indicated to us its agreement with the methodology of validating these patient records through WHC's and Unity's electronic medical records system. The report also illustrates a steady increase in the percentage of patients that had their prenatal care at either WHC or Unity clinics and have delivered at UMC. UMC management also indicated they attribute the Hospital's 27% overall growth in newborn deliveries in fiscal year 2011 to this new relationship, in addition to considerable outreach activities.

Although a breakeven analysis was not provided by management, we believe conservative assumptions indicate additional deliveries of at least 300-400 annually are needed to fund this arrangement with WHC.

This would include professional fees for WHC physicians for all deliveries they perform and hospital revenues for incremental deliveries related to new referrals through this partnership. This positive volume impact was anticipated in the fiscal year 2011 budget:

11 Months Ending August, 2011	Actual	Budget	Variance
Deliveries	525	953	(428)

Without a clear, implementable plan, an exit strategy from the current WHC contract may need to be considered.

A more effective plan that defines success for this partnership needs to be developed and implemented. This would include an ongoing financial analysis, including the impact of any incremental volume via WHC/Unity referrals. The analysis should also include associated Hospital net revenues and marginal expenses, combined with both contract costs paid to WHC (including any on-call fees paid to WHC) and fees collected for WHC-contracted physician services rendered. Based on information gathered through the interview process, this may be difficult because of the changing relationship between WHC and Unity. Without a clear, implementable plan, an exit strategy from the current WHC contract may need to be considered.

Other drivers that have increased deliveries levels include upgraded facilities and technologies as well as the enhanced perception that the Children's National Medical Center (CNMC) pediatric emergency room brings to the UMC medical community.

We would need to see more information to determine if this is a viable product line for UMC under its current structure.

Pediatrics

The CNMC pediatric emergency room was implemented over the past two years. We were advised that a financial analysis of the contractual arrangement has been performed (although not available for our review). The contract with CNMC addresses facility lease arrangements and UMC's provision of ancillary and professional services in support of CNMC physicians. The contract does not address commitments to integrating/aligning this CNMC initiative with the UMC pediatric medical community in a way that enhance UMC's primary care abilities. Rather, the arrangement has been presented as a way to generate a return on unused facilities via lease payments and incremental ancillary volumes supporting pediatric emergency care.

Statistics for the CNMC Pediatric Emergency Room were not provided, so this analysis can only be a cursory review of the impact of this endeavor. It is noteworthy that the UMC adult emergency room's volumes have increased during this period when compared to periods when the UMC emergency room treated adults and children. The transferring of pediatric volume from the existing ED and the concentration on patient throughput in the Adult ED are most likely viewed positively in the community and is resulting in new volume.

Advanced Wound and Hyperbaric Medicine

Of significant pride to all involved at UMC is the growth and image of this product line. Increased volume for the Wound Care Clinic has been experienced in fiscal year 2011:

11 Months Ending August, 2011	Actual	Budget	Variance
Wound Care Clinic Visits	1,656	780	876

In addition to consultative and treatment visits (which are the highest volume), hyperbaric procedures along with visit services performed via the Minimally Invasive Vascular Center are included in these results. Data segregating these three services was not available.

The facilities and technologies for advance wound and hyperbaric medicine are current, well positioning UMC from a clinical and competitive standpoint.

A pro forma was developed by Accelecare (the organization who previously managed the Wound Center) in 2009. UMC has since taken over management of the Wound Center.

The facilities and technologies for advance wound and hyperbaric medicine are current, well positioning UMC from a clinical and competitive standpoint. The presence of three hyperbaric chambers is a significant investment. Since data is not available, it is beyond the scope of this analysis to determine the justification of this level of capacity. In addition, due to the many nuances of wound care billing regulations and the potential for Certificate of Need (CON) requirements to receive payment for hyperbaric treatment via government-funded programs, a more detailed review of actual reimbursement would be needed to determine if this volume is sustained by adequate reimbursement.

The program is oriented to customer service, with measures in place to monitor customer satisfaction. Given there are only two other clinics within the service area (one being in Prince Georges County, Maryland), this clinic is well positioned for meeting a significant portion of the community needs for the many conditions indicated for wound therapy. Even though the number of hyperbaric chambers may ultimately be excessive, this product line has the potential to maintain viability. This could be better confirmed with volume data by mode of service.

Center for Management of Infectious Diseases (CMID)
Aimed at an identified and critical community need, the CMID is oriented to support and augment the primary care needs associated with certain infectious/chronic diseases. There is a 5 year pro forma developed with supporting presentation and proposal materials that depict both a realistic short-term plan and approach and a longer-term vision for the CMID.

The CMID is a newly-created service within UMC. It opened in February 2011. As such, trends are just beginning to be established. Its first year budget was set in concert with the pro forma mentioned above, with volume of activity being tracked monthly.

Activities that have taken place that will be critical to the future sustainability of this program include a significant orientation toward leveraging partner relationships. This includes community, corporate and research partners. In addition, attention to funding partners is already underway. This is depicted by a relationship forged with Family Health International, the goal of which is offering universal HIV testing in the emergency department and inpatient admissions along with the provision of standard-specific care to HIV positive individuals, promoting linkage to supporting primary care services. Reporting and activity monitors have been established and are designed to be consistent with Ryan White Foundation standards.

There are no financial performance reporting tools nor are the fundamental aspects of an implementation plan in place to support this CMID.

There are no financial performance reporting tools nor are the fundamental aspects of an implementation plan in place to support CMID. Framing these aspects into a plan that more specifically identifies management accountabilities would better ensure that it is positioned reasonably for ongoing viability.

Center for Minimally Invasive Vascular Services (CMIVS)
Although this initially was presented as its own product line, the CMIVS presently is housed within the Wound Clinic. A business proposal has been formulated for CMIVS; however, other than lead clinical staff and including the medical staff leader, there is inadequate information to analyze its present status beyond being a viable aspect of the Wound Center.

Center for Diabetes and Obesity

Developed in conjunction with Healing Our Village, this product line is completing its second year in operation. It addresses preserving, restoring and improving the health status of members of the community affected by diabetes. It provides inpatient support and outpatient educational activities. Its business plan addresses the costs associated with chronic diabetes-related complications.

For the first half of calendar 2011, 282 inpatients were seen, an average of 47 a month. This is just over 10% of hospital admissions. There are various quality/process improvement activities evident. It has a fiscal year 2012 goal of increasing the percent inpatient seen by Diabetes Center staff to 15%, and developing and enhancing the inpatient process to facilitate a smoother transition from inpatient to outpatient.

Outpatient activities were more difficult to interpret and analyze. Reporting was not as readily available or discernible. Although there are many educational activities, the number reported for the first six months was 40, an average of less than 7 a month. As outpatient initiatives are increasing, these numbers are projected to change in 2012.

While there is evidence of reimbursement initiatives and awareness, there is not an ability to adequately analyze the financial performance of these services. Historic reimbursement has not rewarded these types of programs directly; their benefit is seen over longer periods of time than a single inpatient encounter. It is this type of program which will be clinically important and rewarded financially in the more managed environment proposed via new health care reform legislation.

Behavioral Health

The need for behavior health services at UMC needs to be examined with other available options and capacities within the District.

In conjunction with Horizon Health, a structured plan and approach to this service has been in place for the past 2 to 3 years to develop this product line. UMC has contracted with Horizon Health, a recognized national organization that provides development and management services for inpatient and outpatient behavioral health for hospitals. This partnership has provided the expertise in improving clinical resources, quality measures, management competencies and business strategy for the behavioral health product line. There is evidence of clinical, regulatory, market and reimbursement awareness. This is critical to have within the unique and challenging mental health delivery environment. Documentation of coordinated care was observed to be a potential unaddressed issue, including infection control and incident data. Trends related to rates of readmission also could pose billing issues.

We noted the availability of financial management reporting was either partial or inadequate (see Exhibit B). As such, we were unable to assess the financial performance of this product line.

Psychiatric admissions for the first 11 months of fiscal year 2011 were 829, compared with 703 experienced in the same period in the prior year. There is also awareness of certain reimbursement actions that could enhance revenues. With the information provided, it is difficult to ascertain actions that have already been taken and what actions are proposed for fiscal year 2012.

The present behavioral health strategies are specifically aimed at inpatient activities and building referral sources for the purposes of improving inpatient volumes. Consideration should be given to more directly address the outpatient/ambulatory behavioral health needs of the community. This would include examining the need for outpatient clinics and other services that would provide a coordinated system of mental health services. Medical staff recruitment efforts could also be enhanced with such expanded services.

The need for behavior health services at UMC needs to be examined with other available options and capacities within the District.

Although, when viewed independently, it is positioned to be a viable product line and not necessarily a service that needs to reside within the UMC facility to be a part of the medical delivery system available to community residents. The need for behavior health services at UMC needs to be examined with other available options and capacities within the District. While there presently are other institutions available to the constituents of the UMC community, capacity constraints may become an issue in the future. The context of addressing this community need should be strategically determined outside the context of making a viable product line at UMC and within the context of how best to meet the community needs given all other providers available in the market place. Established mental health outpatient clinic services (as mentioned above) would make the potential of utilizing another facility for inpatient needs more viable.

We have been informed by UMC management that a Request for Proposal (RFP) has been issued to qualified organizations for the purpose of providing administrative and clinical management of the Behavioral Health program. This would be an expansion of the services Horizon Health has been providing. Although this RFP was not available for review, management indicated it is inclusive of provisions for management and physician staffing to provide program leadership. Criteria to be addressed by responders also include addressing potential opportunities such as an outpatient clinic, an adolescent program, and programs for alcohol and substance abuse. The inclusion of physician services in this proposal may better address certain opportunities related to physician staffing and the associated reimbursement. However, we believe the timing of this RFP is not ideal, as the overall future of UMC and its various programs is currently being evaluated. Additionally, the introduction of a new physician arrangement related to psychiatric services needs to be coordinated with the previously recommended physician alignment actions.

Nursing Center –Skilled Nursing Facility (SNF)

The floors are hospital-like in appearance and are not designed to meet the needs of SNF residents, which are many times dissimilar from acute hospital patients needs.

As this product line expands its scope to encompass 120 beds, it now occupies two floors of what had been hospital acute care units. The floors are hospital-like in appearance and are not designed to meet the needs of SNF residents, which are many times dissimilar from acute hospital patients needs. This is an example of what seems to be a UMC struggle to integrate the various unique requirements of a SNF, which are often different from the requirements and regulations of an acute hospital.

Given the level of facility commitment, the need for a strategic-oriented business plan is significant for this product line. Without this planning structure, the orientation has tended toward occupying as many beds as possible. This has the potential of not addressing certain populations within the community. It may also foster attracting a difficult-to-manage disparate mix of SNF residents. Presently, this would seem to be the case given the resident population is observed to be of mixed ages, as well as varied medical conditions. This variation of resident circumstances makes activity programming difficult, reducing the desirability of the SNF facility for potential residents and their families who have the ability to discern and choose between facilities. This is compounded by the present facility limitations. The SNF units are former hospital acute units with limited square footage for SNF-related resident activities.

At present, the SNF does not have a hospice provider arrangement.

At present, the SNF does not have a hospice provider arrangement. As the Medicare population becomes a greater percent of residents, the need to have a more formal end-of-life capability will be both appropriate and an expectation. This is planned to be addressed in 2012. A hospice provider arrangement is a common component of most SNFs. All other SNFs in the District have this capability. It is an indicator that the resident population has been predominately non-senior patients with Medicaid insurance.

SNF management credentials/capabilities are appropriate and adequately meet regulatory requirements. They present a sound understanding of what is required to operate a SNF appropriately. Metric goals are in place for both clinical and operational performance.

The SNF is in the final stages of a prolonged process to obtain its Medicare Provider Number. This number has created a backlog of Medicare bills accruing since October 2010. Having this ability completed and implemented is an obvious necessity and should be able to be addressed in the near term. Given the length of time associated with the delay in receiving this Provider Number, there is an increasing risk of payment denial for services provided during this period. This should be a one-time situation, assuming a proper Medicare submission process is in readiness once the number is released.

Commenting on the viability of the SNF product line is overshadowed by the need to comment on the strategic need for a SNF in the middle of an acute facility. However, this is outside the scope of the review undertaken. It would require better understanding of the capacities of exiting SNF facilities around the DC area. Certain information was obtained regarding the other 18 District nursing facilities. This information describes service capabilities but not capacity potentials.

Further analysis of the SNF operation is included in the "Skilled Nursing Facility Assessment" section of this report.

Emergency Services

As previously mentioned, Emergency Services are critical as both an initial point of contact for many patients, as well as a feeder to the product lines noted. Trends in emergency visits since the beginning of 2009 are:

	ER Visits	Percent Inc./(Dec.)
January to June 2009	19,141	5.0%
July to December, 2009	20,618	7.7%
January to June, 2010	20,503	(0.6)%
July to December, 2010	21,935	7.0%
January to June, 2011	23,252	6.0%

The trends experienced during 2011 have even more significance given the opening of the Pediatric Emergency Department this year, which removed pediatric volumes previously included (and reported) in these statistics.

The trends experienced during 2011 have even more significance given the opening of the Pediatric Emergency Department this year, which removed pediatric volumes previously included (and reported) in these statistics.

Patient flow and customer satisfaction initiatives are in place to address key performance metrics, including improving the percent of patients who leave without treatment. The performance factors utilized are those common within hospitals and serve as a basis for performance monitoring.

An issue that will continue to surface is the vast difference in the facility that houses the Pediatric Emergency Department versus the Main Emergency Department. The stark contrast, particularly in technology and aesthetics, is noted by patients, physicians and UMC employees.

Radiology

The scope of services within Radiology is typical and reasonable for an institution the size of UMC. This includes the ability to support a program such as the Center for Minimally Invasive Vascular Services via the Philips Allura dual purpose special procedures unit. Many core technologies are at, or near state-of-the-art levels, with the exception of the present mammography equipment and an older secondary CT unit that serves as a backup unit. Plans have been put forward to enhance mammography to current best technology levels.

The scope of services within Radiology is typical and reasonable for an institution the size of UMC.

The new contract with Progressive Radiology provides the potential for clinical and business enhancement. An established group, Progressive Radiology brings both a high level of clinical expertise as well as solid business acumen. This provides an ability to foster an enhanced imaging referral stream in place, allowing for service line outreach and primary care development to be supported properly. In may also be the basis for new referral sources. Progressive Radiology began its new contract at UMC in August 2011, so volumes are just beginning to be impacted by this radiology group.

Radiology volumes for calendar 2011 are approximately 8.5% greater than those experienced in the previous year. This can be attributed to outpatient and emergency (including Peds ED) services.

Chapter 3: Joint Commission Readiness Assessment

Summary

From August 22 through 26, 2011 we performed an on-site regulatory and accreditation assessment. Hospital leadership and staff members are to be commended for their cooperation and receptivity during the review process.

In performing the "high level" assessment of compliance with The Joint Commission (TJC) standards, team members completed patient care and system tracers; interviewed key leaders during Leadership, Performance Improvement, and Medical Staff sessions; and reviewed select medical records, policies and procedures, and document binders prepared for the expected upcoming Joint Commission survey. A tracer is a process utilized by TJC whereby a clinical event is traced from its origin through its conclusion/discharge to ensure underlying documentation is complete and adheres to all applicable standards and requirements. It should be emphasized that this was a "high level" survey; it was not an all inclusive assessment of every standard or element of performance (EP). The standards and EPs assessed were selected generally because they are "direct impact", previously cited on a recent TJC survey at UMC, and/or are commonly problematic/likely to be cited during an actual TJC survey. We emphasize that it should not be assumed that merely because a finding of non-compliance is not mentioned, that the Hospital is compliant with that standard.

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UMC management is aware that an actual TJC survey could occur at any time and for certain standards a twelve month track record of compliance must be evident.

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The following report includes:

- Findings of the high level assessment in a Dashboard Format by TJC Chapter
- Overall Impressions and Recommendations by TJC Chapter

Accreditation Participation Requirements (APR)

Summary Assessment: ***Red***

During the assessment of the Operating Room area, a surgeon was found to have written a post-op diagnosis and a post-op disposition of a patient pre-operatively. When queried, the surgeon indicated this was the surgeon's usual practice. Medical staff leadership took immediate action when the situation was discovered. Since this practice can hire serious consequences, even be considered fraud and falsification of records by TJC and Centers for Medicare and Medicaid Services (CMS), it is imperative that the actions initiated by UMC

Since this practice can hire serious consequences, even be considered fraud and falsification of records by TJC and Centers for Medicare and Medicaid Services (CMS), it is imperative that the actions initiated by UMC leadership to address this situation be fully completed as soon as possible.

leadership to address this situation be fully completed as soon as possible.

As stated in the Rationale for APR.01.02.01, “Any hospital that fails to participate in good faith by falsifying information or by failing to exercise due care and diligence to ensure the accuracy of information may have its accreditation denied or removed by The Joint Commission.”

Our recommendations for the Hospital are as follows:

- Continue investigation to determine if the practice is more widespread than one individual.
- Conduct education to ensure practitioners understand the serious nature of the practice.
- Educate/reeducate nursing staff to assist in the identification of the practice before a case begins.

Environment of Care (EC)

Summary Assessment: **Red**

Seven of the 20 (35%) elements of performance in EC.02.03.05, including testing of various fire safety system components, did not have the required 12 month testing track record, as required. Leaders of the environment of care are aware of this deficiency and are actively taking steps to correct the situation. Due to the seriousness of this situation, the failure to test these components as required causes the standard to be scored “red”. It is not possible to develop a 12 month track record of compliance in this standard.

Failure to consistently test critical components of the fire safety systems represents a breakdown in effectively managing the risks in their environment.

Failure to consistently test critical components of the fire safety systems represents a breakdown in effectively managing the risks in their environment. Steps need to be taken to ensure that testing of these components be scheduled and completed timely and on an ongoing basis.

Our recommendations for the Hospital are as follows:

- Complete testing of components to ensure all untested components have been tested as soon as possible.
- Develop testing plan for future to make sure no components go untested to ensure ongoing compliance.
- Develop a project plan to identify dates for upcoming testing and communicate to leadership to ensure compliance in future periods.

Emergency Management (EM)

Summary Assessment: ***Yellow***

In the EM session following the earthquake on August 23, 2011, there was a discussion of the notification process in the current Emergency Operations Plan (EOP). The current plan called for notification of staff and Licensed Independent Practitioners (LIPs) via phone. Most staff and LIPs use cellular phones and it was noted that many of the cellular phones were not operational for voice communication following the earthquake. It was suggested that other notification options be included in the plan such as text or email.

There was no documentation available during the EM session that the Hospital had communicated in writing to each of the LIPs regarding his or her role in an emergency response and to whom he or she reports. It is important in an emergency that LIPs understand their role in the response and to whom he or she reports.

Documentation of the evaluation of emergency response exercises is critical to the performance improvement process in EM.

Finally, there was no documentation available of the evaluation of emergency response exercises or responses to actual emergencies that included the identification of deficiencies and opportunities for improvement. Documentation of the evaluation of emergency response exercises is critical to the performance improvement process in EM.

Our recommendations for the Hospital are as follows:

- Revise EOP to include additional notification options other than cellular phones.
- Write and distribute to LIPs their role in emergency response and to whom they report.
- Document evaluations of emergency response exercises and actual emergencies to include identification of deficiencies and opportunities for improvement.

Human Resources (HR)

Summary Assessment: ***Yellow***

A great deal of good work is being conducted in the HR area.

A great deal of good work is being conducted in the HR area. The chapter was scored “yellow” because several personnel files were missing the required sign-off (staff initials required by UMC) on the verification of licensure document. The personnel files were also missing required sign-offs. One of the nurse practitioner files was missing verification of licensure.

Since verification of credentials is critical at the time of hire and when credentials are renewed, it is imperative that the required steps in verifying licensure are performed with accuracy and consistency.

Our recommendation for the Hospital is as follows:

- Develop a process for 100% review of staff and LIP files to ensure proper credentials verification.

Infection Prevention and Control (IC)

Summary Assessment: ***Yellow***

The data for hand hygiene compliance by infection control staff indicated compliance was as high as 92% and 94% in two recent months.

As noted in the National Patient Safety Goals chapter which follows, several deviations from the prescribed hand hygiene protocol were observed during patient tracers and tours. The data for hand hygiene compliance by infection control staff indicated compliance was as high as 92% and 94% in two recent months. These are very high rates of compliance; however, we observed several instances where the proper protocol was not followed.

During patient tracers, a nurse was observed using a pill crusher that was not cleaned before or after use. Another nurse used her stethoscope on a contact isolation patient and left the room without cleaning it. Both of these actions represent opportunities for improvement.

Our recommendations for the Hospital are as follows:

- Continue to educate and reeducate caregivers on the hand hygiene protocol.
- Continue to measure staff compliance with the hand hygiene protocol.
- Make certain hand hygiene monitoring is accurately assessing the compliance rate with the hand hygiene protocol.
- Continue to educate staff about the importance of maintaining proper infection control measures to prevent the spread of infection.

Information Management (IM)

Summary Assessment: ***Yellow***

During one of the patient tracers, it was noted that the current order form did not contain all of the Do Not Use options listed in IM.02.02.01, EP3. While these options may appear relatively minor, it is important that the Do Not Use list be 100% complete. There was no observed documentation delinquencies related to use of Do Not Use abbreviations.

Our recommendation for the Hospital is as follows:

- Revise the order form to include ALL of the Do Not Use abbreviation options.

Leadership (LD)

Summary Assessment: ***Yellow***

The governing body does not provide the organized Medical Staff the opportunity to participate in governance. Accrediting body standards specify that organized Medical Staff members are eligible for full membership in the Hospital's governing body, unless legally prohibited. As the governing body is ultimately accountable for the quality and safety of care, it is very important to have members of the Medical Staff participate in the governing structure.

This lack of full participation in the form of voting membership on the Board is creating considerable conflict with the Medical Staff.

This lack of full participation in the form of voting membership on the Board is creating considerable conflict with the Medical Staff. Accrediting body standards also require the Hospital to implement a conflict resolution process for the Board and organized Medical Staff to use when conflicts arise between them, to prevent adverse effects on patient safety or quality of care.

A number of policies and procedures were found to be outdated. It appeared there was not a systematic process to ensure policies and procedures were reviewed according to the Hospital's specifications.

Our recommendations for the Hospital are as follows:

- Consideration should be given to developing and implementing a strategy whereby Medical Staff has the opportunity to fully participate in governance.
- The by-laws of the UMC Board should be reviewed and modified to ensure a process for resolving conflicts between the Board and the organized Medical Staff exist.
- Develop a systematic process to ensure all policies and procedures are reviewed according to the required interval.

Life Safety Code (LS)

Summary Assessment: ***Red***

The potential harm that could ensue from the failure to correct Life Safety deficiencies in a timely manner could be substantial.

A recent survey performed by an organization hired by UMC identified more than 800 LS code deficiencies such as penetrations, unapproved hold open devices, missing fireproof insulation and many others. Approximately 45 of the 800 LS code deficiencies are being evaluated to determine whether they will be added to or have already been included on the electronic Statement of Conditions. The current electronic Statement of Conditions has 24 plans for improvement, 23 have not yet been approved by TJC. The potential harm that could ensue from the failure to correct Life Safety deficiencies in a timely manner could be substantial.

The surveyor sign-off of the electronic-Statement of Conditions from the December 2008 survey could not be located. It is recommended that the document be located to make sure the Hospital has knowledge of which Plans for Improvement were completed during the last accreditation cycle.

The Hospital needs to make sure there is an effective, ongoing process which immediately corrects the existing LS deficiencies and identifies future concerns on a timely basis. The Hospital must remain vigilant in maintaining compliance with life safety standards since fire is such a critical concern in facilities where patients have difficulty and/or are often unable to move to safety by themselves. Maintaining strict compliance with life safety standards is essential.

Maintaining strict compliance with life safety standards is essential.

Our recommendations for the Hospital are as follows:

- Complete repair of all outstanding life safety deficiencies as quickly as possible.
- Develop a repair plan for the future to make certain all deficiencies are corrected as soon as possible.
- Develop a project plan to identify processes for inspecting all life safety codes standards and communicate to leadership the plan to stay in compliance with these issues.
- Locate the document the LS surveyor signed off during the December 2008 survey to make certain the Hospital is aware of which Plan for Improvement (PFIs) were complete during that cycle.

Medication Management (MM)

Summary Assessment: ***Yellow***

MM is one of the Hospital's Priority Focus Areas, and thus may receive targeted scrutiny during an actual TJC survey.

Some significant findings of non-compliance were observed during tracers, as well as during "spot checks" of medical records.

Some significant findings of non-compliance were observed during tracers, as well as during "spot checks" of medical records. Examples (not an all inclusive list) include:

- Concentrated electrolytes were not isolated from other medications.
- Medication orders did not always include all required information.
- Required clarification by Pharmacy and Nursing did not always occur when medication orders were unclear.
- Nurses did not always check all required elements before administering medications.

For example, there is extensive use of verbal orders throughout the Hospital, though this practice is not considered a good practice by TJC.

The examples above are “direct impact” elements of performance. In addition, there were several findings of non-compliance with other elements of performance. For example, there is extensive use of verbal orders throughout the Hospital, though this practice is not considered a good practice by TJC. Also, of note, is the fact there were findings of non-compliance with standards cited during the 2008 survey.

Serious consideration was given to scoring this chapter “red”. “Yellow” was chosen for the following reason:

- The organization appears to have the resources and leadership commitment necessary to implement changes required to achieve compliance. There were no findings that are “non-recoverable”. However, intense focus, and some change in culture (e.g., decreased use of verbal orders, and careful attention to detail) will be necessary for the Hospital to have a successful survey in this area. Action plans needed to correct non-compliance should not be beyond the capabilities of the organization.

Our recommendations for the Hospital are as follows:

- Implement action plans to remedy deficiencies identified.
- Initiate educational sessions for physicians and nurses on standards and elements of performance in this chapter, and emphasize the importance of safe medication management.
- Ensure staff members clearly understand how compliance with the standards should guide their practices.
- Implement process to further assess and monitor compliance with each element of performance in this chapter going forward.

Medical Staff (MS)

Summary Assessment: ***Yellow***

During the high level assessment of the MS chapter, findings of non-compliance were identified in all areas reviewed (and not all sections of the chapter were reviewed). Examples of non-compliance include:

- Implement action plans for deficiencies identified during this review (i.e., establish/improve processes to ensure that credentials files contain all required information).
- Some credential files did not include every required piece of documentation. For example, primary source verification of licensure was missing in the file of an Advanced Practice Registered Nurse.

- As indicated by Medical Staff Office personnel, Focused Professional Practice Evaluation (FPPE) is lacking.
- Ongoing Professional Practice Evaluation (OPPE) is in the early stages of implementation; although begun, it is not fully implemented.

None of the above is a “direct impact” element of performance.

Some consideration was given to scoring this chapter “red” since it is highly unlikely that an FPPE will be in place before the actual TJC survey takes place, and significant challenges exist in other areas reviewed. However, “yellow” was chosen mainly for the following reason:

- No “direct impact” elements of performance were identified as being non-compliant.

The Hospital is aware much work is required to bring this chapter into compliance. Timelines are in place to address some of the required improvements, but not all, needed improvements.

Our recommendations for the Hospital are as follows:

- Implement action plans for deficiencies identified during this review for which the organization was not aware, i.e., establish/improve processes to ensure that credentials files contain all required information.
- Continue to execute timelines and action plans already in place to fully implement OPPE.
- Begin timeline/action plan to implement FPPE.
- Correct known “disconnect” in bylaws dealing with Advanced Practice Registered Nurses.
- Undertake detailed review of Medical Staff by-laws, rules and regulations, and policies to ensure compliance with standards. High level nature of our review did not allow for an element-by-element assessment.
- Similarly, undertake more in-depth review of credentialing and privileging processes to ensure compliance with standards.

National Patient Safety Goals (NPSG)

Summary Assessment: ***Yellow***

We observed lapses in compliance with NPSG during tracers. Furthermore, lack of consistent compliance with these standards does not convey a good first impression nor reflect an organization that puts patient safety first.

We observed lapses in compliance with NPSG during tracers. For example, two patient identifiers were not used each time required and a time-out was not conducted properly prior to start of a surgical procedure. These deficiencies are critical, "direct impact" elements of performance where the institution was not in compliance.

Furthermore, lack of consistent compliance with these standards does not convey a good first impression nor reflect an organization that puts patient safety first.

In addition, we again emphasize that time limitations of our review did not permit an extensive assessment of these standards. Serious consideration was given to scoring this chapter "red"; "yellow" was chosen for the following reasons:

- The organization appears to be in compliance with many other direct impact elements of performance. Though not all-inclusive, examples include approved protocols are used for the initiation and maintenance of anticoagulant therapy; when heparin is administered intravenously and continuously, programmable pumps are used; a standardized supply cart or kit that contains all necessary components for the insertion of central line venous catheters is used; site marking for the universal protocol was done as required; documentation existed for completion of time-outs as required by the universal protocol.
- The organization appears to have the resources and commitment at the leadership level necessary to implement the education and monitoring that will be required to achieve compliance. Action plans needed to correct non-compliance should not be beyond the capabilities of the organization.

Our recommendations for the Hospital are as follows:

- Implement intensive educational sessions on all NPSG—emphasizing the criticality of compliance and the fact that attention to every detail in the elements of performance is important. Staff actions need to be purposeful and consistent, and convey that the steps taken while providing care are important for patient safety (and are not being done merely to be compliant with TJC).
- Implement process to monitor compliance with these standards, with special emphasis on use of two person identifiers and universal protocol.

Nursing (NR)

Summary Assessment: ***Yellow***

During the course of this high level assessment, the role of the Chief Nursing Officer (CNO) appeared to be in compliance with standards in the NR chapter, i.e., she seemed to be an integral part of the Hospital leadership team, and had the authority for and oversight over all nursing functions in the Hospital. In addition, the Hospital is in compliance with the two "direct impact" elements of performance in this chapter, specifically: (1) the nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week; and (2) a registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week. Based on those facts, consideration was given to a summary assessment of "green" for this chapter. However, "yellow" was assigned—even though there is only one "Finding" in the main report—since there is some concern that an actual TJC surveyor may take a more critical stance in the NR chapter due to the lapses in adherence by members of the nursing staff to policies and procedures that were identified in the other chapters. A possible citation on these grounds would not be "direct impact".

Nursing leadership is critical to ensure staff members adhere to established policies and procedures, are aware of how and where to access the policies and procedures, and that policies and procedures are up to date and incorporate the most current standards.

Nursing leadership is critical to ensure staff members adhere to established policies and procedures, are aware of how and where to access the policies and procedures, and that policies and procedures are up to date and incorporate the most current standards. "Yellow" has been assigned to underscore the importance of these issues.

Our recommendations for the Hospital are as follows:

- Review and update existing nursing policies and procedures to ensure they provide clear guidance, and that they are current.
- Educate/reeducate nursing staff as needed, emphasizing the need to comply with policies and the rationale for so doing.
- Identify and address barriers causing lack of adherence to policies and procedures.
- Instill a sense of individual accountability; staff nurses should know where to find policies.
- Implement more robust processes to monitor compliance with policies and procedures.

Provision of Care, Treatment, and Service (PC)

Summary Assessment: ***Yellow***

Significant findings of non-compliance were observed during tracers and spot checks of medical records.

One of the Hospital's four Priority Focus Areas is Assessment and Care/Services, in essence the areas covered in the PC chapter. Like the other Priority Focus Areas, standards in this chapter may receive targeted scrutiny during an actual TJC survey.

Significant findings of non-compliance were observed during tracers and spot checks of medical records. Examples (not an all inclusive list) include:

- Initial pain assessments were not always complete.
- Reassessment of pain was not always done when required; current method of documentation precludes assurance that timeliness of reassessment meets requirements.
- Pre- and post-anesthesia evaluations did not always meet standards.

The examples above are "direct impact" elements of performance. In addition, there were several findings of non-compliance with other elements of performance. For example, nursing admission assessments were not always complete; nursing care plans were not always individualized or updated.

On balance, however, the Hospital appears to be in compliance with other elements of performance, some of which are direct impact. For example:

- The Hospital has written criteria for describing early warning signs of a change of deterioration in a patient's condition and when to seek further assistance (and all staff queried promptly described when and how they would call the Rapid Response Team).
- An observed hand-off of a patient between two staff nurses conveyed pertinent information in a professional manner; change of shift reports provide for the opportunity for discussion between the giver and receiver of patient information (i.e., they are face-to-face).
- A diabetic patient received a visit from the Diabetic Educator; teaching done during the observed session addressed one of the patient's key learning needs.

The scope of care processes covered in the PC chapter is extensive, so a summary assessment, especially a high level one, should be viewed with caution. Although this caveat has been expressed for other chapters, it is particularly relevant here. Many standards were

not assessed, and the presence of illegible, untimed medical record entries, made assessment of others difficult.

After careful consideration, “yellow” was chosen for the following reason:

- There was no finding that was “non-recoverable”. As mentioned in the summary statement of the Medication Management chapter, however, intense focus, re-education, and some change in culture (e.g., attention to detail) will be necessary for the Hospital to have a successful survey in this area. Although needed corrective action plans to address deficiencies will require much time and attention from the Hospital, they should not be beyond the capabilities of the organization.

Our recommendations for the Hospital are as follows:

- Implement action plans to remedy deficiencies identified.
- Set clear expectations, and hold staff accountable.
- Ensure policies and forms are consistent, reflect the most current standards, and facilitate compliance with standards to minimize potential confusion for staff.
- Emphasize that attention to detail is important.
- Implement process to further assess and monitor ongoing compliance with standards in this chapter. Make use of assessment/monitoring process to educate staff to improve familiarity with requirements.

Performance Improvement (PI)

Summary Assessment: ***Yellow***

Hospital leadership appears to take performance improvement very seriously; it is a priority. In our opinion, UMC is working diligently to strengthen its program, describes it as “evolving”, and appears to have established timelines for addressing outstanding issues.

PI is one of the Hospital’s Priority Focus Areas, and thus may receive targeted scrutiny during an actual TJC survey.

Overall, the Hospital appears to be in compliance with most of the standards reviewed in the PI Chapter. It is collecting and analyzing required data, and taking actions to make improvements. Specific examples include changes implemented after reviewing the results of resuscitation, and PI projects focused on improving ED through-put. It also has data to support the effectiveness of its Rapid Response Team.

As hospital leadership acknowledges there is concern about the potential under-reporting of data, such as significant adverse drug reactions, and in certain areas not all of the underlying structural components are in place to fully support a coordinated approach to make use of data collected and analyzed.

Hospital leadership appears to take performance improvement very seriously; it is a priority. In our opinion, UMC is working diligently to strengthen its program, describes it as "evolving", and appears to have established timelines for addressing outstanding issues. Although significant challenges exist to realize needed improvements, the Hospital appears to have the talent and dedication needed to make progress toward its goals.

In light of the above, a summary assessment for this chapter is "yellow".

Our recommendations for the Hospital are as follows:

- Continue to implement plans and timelines.
- Revisit data collection and reporting processes to ensure accuracy of data collecting/reported.
- Re-evaluate previously implemented actions that have not led to improvements; continue to access, identify and address additional barriers to improvement.

Record of Care, Treatment and Service (RC)

Summary Assessment: ***Yellow***

Leaders informed the surveyors that 100% of physicians are being reviewed as part of a Medical Staff initiative to improve documentation.

During individual patient tracers multiple instances were noted where records had entries which were not signed, dated or timed. Leaders informed the surveyors that 100% of physicians are being reviewed as part of a Medical Staff initiative to improve documentation. Sixty records per month are being reviewed for completeness of entries as well as other issues.

Our recommendation for the Hospital is as follows:

- Review existing record review process to make sure it is identifying 100% of the entries without the proper date, time and signature.
- Make certain LIPs and staff are receiving feedback regarding performance improvement opportunities.
- Continue to monitor and improve performance as needed.

Rights and Responsibilities of the Individual (RI)

Summary Assessment: ***Green***

No findings in the RI chapter were identified.

Transplant Safety (TS)

Summary Assessment: ***Green***

No significant issues were identified during the high level assessment of the TS chapter. The Hospital has a signed written agreement with an Organ Procurement Organization (OPO), and discussion during the PI interview session indicated that the Hospital is analyzing its organ procurement conversion rate data provided to it by the OPO. Although the Hospital has harvested tissues/organs for transplant, this is not a high volume service at the Hospital; the Hospital does not perform organ transplants.

Our recommendation for the Hospital is as follows:

- Implement process to assess each element of performance in this chapter, where applicable, with a focus on direct impact elements of performance. Undertake corrective actions if deficiencies are identified. (Note: In light of the other pressing issues facing the Hospital, this area would not be a priority focus).

Waived Testing (WT)

Summary Assessment: ***Green***

Skill sets for staff that perform waived testing are current; glucometers "lock out" anyone who is not current.

No significant issues were identified during the high level assessment of the WT chapter. Standards in this chapter were reviewed during an interview session with the Director of the Laboratory and others responsible for the waived testing program. They were well versed in the regulatory/accreditation requirements. Log books were also examined on an inpatient unit and in the OR area and staff readily explained how their competency was assessed.

The need to modify one form was addressed during the interview session. Skill sets for staff that perform waived testing are current; glucometers "lock out" anyone who is not current.

Chapter 4: Internal Controls over Financial Reporting

Summary

Under the District of Columbia Home Rule Act, the District Office of the Chief Financial Officer (OCFO) has oversight, authority, and responsibility for virtually all financial aspects of each agency within the District. This includes, but is not limited to, cash management, procurement, disbursement processing, administrating financing arrangements, and financial accounting and reporting. As an agency of the District, the Hospital is not exempt from this Act. It is our understanding the structure of this oversight, authority and responsibility can be tailored to satisfy the provisions of the Act, as well as the business needs of the agency.

In each internal control area evaluated, we noted an absence or insufficient formal, documented, statements of operating procedures (SOP).

In each internal control area evaluated, we noted an absence or insufficient formal, documented, statements of operating procedures (SOP). We did, however, observe some level of documented policies and procedures for certain functions, such as the Patient Financial Services (PFS) department. It is considered best practice to formally document policies, procedures and controls for all functions and transaction cycles critical to the financial reporting process. Such documentation provides clarity to employees related to their role and responsibilities, enables management to evaluate staff performance and process efficiency, and establishes accountability, which collectively ensures accurate, consistent, timely and reliable financial reporting.

Overview

We documented our understanding of UMC's internal controls over financial reporting. Our understanding was primarily developed from interviews with UMC personnel and review of documented policies and procedures. Based on our understanding of UMC's internal controls over financial reporting, we designed tests to validate the controls are functioning as designed.

Internal controls over financial reporting evaluated include:

- Accounting systems and IT components.
- Billing, patient receivables, and cash receipts.
- Inventory, procurement, accounts payable and cash disbursements.
- Acquisition, depreciation and disposal of property and equipment.
- Payroll.

- Identification and monitoring of loss contingencies.
- Monthly and annual closing processes.
- Preparation of UMC's financial statements, including note disclosures.

We selected a sample of transactions for each relevant transaction cycle and tested each transaction against the key control attributes identified. We also reviewed underlying documentation for each transaction to substantiate its propriety.

Based on our understanding of UMC's internal controls over financial reporting and results of our tests of internal controls, we documented all identified deficiencies in the design or operation of UMC's internal controls over financial reporting.

We reviewed UMC's note disclosures to its annual financial statements and assessed potential significant omissions and/or departures from generally accepted accounting principles (GAAP) in the United States of America. Our assessment considered the results of our internal controls testing and substantive tests of transactions, as well as observations from time spent on-site at UMC and review of relevant GAAP disclosure checklists.

In addition, we performed a variety of procedures to identify contingent liabilities of UMC, including a review of malpractice claims and related insurance documents, to ascertain any pending litigation and liability associated with such litigation.

All patient and financial information and activity of the Hospital is captured, processed and reported through MEDITECH. MEDITECH is a comprehensive and integrated Health Care Information System.

Our recommendations for the Hospital are as follows:

Information Technology (IT):

- Conduct a comprehensive financial review of payments to MEDITECH for initial installation, and ongoing licensing, maintenance and support.
- Implement an IT Governance Framework to ensure internal controls are in place for large IT procurements.
- Develop and formally document a policy requiring the completion of a periodic risk assessment encompassing all IT systems and applications which store, process, or transmit patient health information.
- Conduct a thorough baseline assessment of the Hospital's IT infrastructure to ensure it can meet the meaningful use requirements to support Electronic Health Records.

- Develop a comprehensive contingency/disaster recovery plan.

Patient Billing & Collections:

- Policies and Procedures:
    - Revise the Billing and Cash Posting manuals to detail all policies and procedures related to these functions, including illustrations and process flowcharts, to provide clear, step-by-step instruction.
- Charge Entry:
    - Establish a routine process for clinical departments to review revenue reports on a monthly basis and investigate/resolve variances from expectations.
    - Establish procedures whereby clinical departments capture sterile processing and delivery (SPD) and supply charges in MEDITECH to increase accountability and billing accuracy.
- Chargemaster:
    - Establish procedures to routinely update the chargemaster to ensure it is current at all times.
- Claim Monitoring:
    - Establish a mechanism for the Medical Records Department to expeditiously review the status of claims submitted and reasons for denials to ensure each clinical department is actively involved and accountable for achieving the billing goals of the Hospital.
- Uncollectible Patient Receivables:
    - Ensure established protocol with respect to write-off of uncollectible patient receivables is consistently followed.
    - Aggressively pursue delinquent patient accounts by leveraging a collection agency, as necessary.
    - Increase scrutiny over the evaluation of the adequacy of allowance for uncollectible patient accounts and contractual allowance reserves. Application of the Hospital's policies should not be overly aggressive or conservative.
- Charity Care:
    - Ensure established protocol with respect to approval of charity care is consistently followed.

Acquisition, Depreciation and Disposal of Property & Equipment:

- Tailor the asset capitalization policy to be more specifically applicable to UMC's operations.
- Utilize the subsidiary property and equipment ledger feature of MEDITECH to maintain a more secure, reliable and accurate database of all property and equipment of the Hospital.
- Establish procedures to periodically inventory property and equipment of the Hospital.
- Establish procedures to assess potential impairment of property and equipment.

Materials Management/Supplies and Pharmacy Inventory:

- Utilize the inventory usage threshold features of MEDITECH to better manage inventory needs and increase accuracy of patient billings for SPD and supplies.
- Ensure proper segregation of duties for requesting and verifying receipt of goods and services.

Identification and Monitoring of Loss Contingencies:

- Formally document policies and procedures related to insurance coverage requirements, settling claims, and recording malpractice, general liability and workers compensation liability reserves.
- Maintain a current and complete claim/incident log that tracks potential claims, asserted claims, closed claims, and claims being actively defended.
- Implement a formal process to evaluate claims/incidents and establish a loss reserve for unresolved activity.

Completeness of Note Disclosures to UMC's Financial Statements:

- Perform an analysis of the potential liability related to the remediation of asbestos, and consider its significance to the Hospital's financial statements and note disclosures.

Accounting System and Information Technology (IT) Review

IT Contract Management

We reviewed a sample of IT contracts to determine if these contracts were executed in good faith, free of duplicate efforts, and adequately monitored by UMC personnel. The IT contracts reviewed are as follows:

Contract	Dated
Passport	January 25, 2007
EmpowER	September 26, 2008
Kronos	January 12, 2001
MEDITECH	March 12, 2008 November 6, 2007 December 28, 1998 May 2000
MEDITECH	May 17, 2010
Newbold	May 28, 2008
GRM	March 8, 2011

We noted the MEDITECH contract and related extensions contained numerous manual corrections, including edits to the hospital name.

We noted the MEDITECH contract and related extensions contained numerous manual corrections, including edits to the hospital name. We discovered an initial payment of $1.3 million for procurement of MEDITECH with a perpetual license as documented in the amendment dated May 2000, “Greater South East Community Hospital under Article II-C Delivery schedule”. Following the initial payment, another payment of $1.0 million was made for “License Transfer” on November 8, 2007 for the same software, which may be indicative of double payment for procurement of MEDITECH.

We determined the scanning conduct with GRM Information Management Services, Inc. contract is deficient as an adequate scope of work, list of deliverables, and schedule of reporting requirements to UMC management has not been established. The scope of work presented in Attachment A within the contract lacks deliverables, performance measurements, and specificity of services provided. Scope of Work is a vague three lined statement that is not sufficient for a contract valued at $144,000.

The price schedule presented under Attachment B of the contract also lacks information with regard to payment procedures based on deliverables and performance or evaluation based invoicing. The rates offered do not cover the above mentioned criteria or mention dates of assessment.

Our recommendations for the Hospital are as follows:

- Conduct a comprehensive financial review of payments to MEDITECH for initial installation, and ongoing licensing, maintenance and support. Also, examine and assess rationale for $1.0 million paid in 2007 for an existing MEDITECH perpetual license.
- GRM contract should be reviewed to address the above stated deficiencies.
- Implement an IT Governance Framework to ensure internal controls are in place for large IT procurements.

- Create a requirement for service providers to detail the range of services to be provided under the scope of work, or similar subcategory. Also, service providers should be required to provide periodic quality assessment reports to the Hospital and price schedules should include a clause that specifies periodic performance evaluations before releasing payment to the service provider.

General IT Security Controls (GSS)

We conducted a review of limited GSS to advise UMC management on control weaknesses that may require immediate attention, and also to provide an independent assessment of the Hospital's security posture to meet security and business continuity needs. We utilized the Federal Information Security Audit and Controls Manual and limited our activities to review of:

- Security Management
- Configuration Management
- Contingency Planning

The Federal Information System Controls Audit Manual (FISCAM), states that general IT security controls are the structure, policies, and procedures that apply to an entity's overall computer operations, ensure the proper operation of information systems, and create the environment for application systems and controls. General controls protect networks, safeguard data, and prevent unauthorized access to software. The effectiveness of general controls is a significant factor in determining the effectiveness of application controls. Without effective general controls, application controls "can generally be rendered ineffective by circumvention or modification." We did not review access control and segregation of duties for MEDITECH, due to the limited nature of our engagement.

In reviewing the above control objectives, we developed and completed a comprehensive survey questionnaire that included the following topics:

- Physical and Environmental Controls
- Logical Security Controls
- Backup, Media Control and Data Retention
- Change Control
- Contingency Planning
- Vulnerability Assessment
- Network Security
- System Connectivity

- Circuit Security
- Remote Access
- Wireless Security
- Network Support
- PC Support
- Malicious Code Protection
- Firewall

We obtained information through interviews with concerned individuals to determine adequacy of security controls, requested special reports to determine adequacy and operations of security controls as designed, and reviewed other documentation made available (e.g., network diagrams, data flows, encryption mechanisms, future plans, etc.).

In our initial observation, we determined there is adequate physical, environmental and network security in place, however, there is a need for improvement for IT staffing, security management, configuration management and contingency planning.

This challenge is currently being handled at an adhoc level with no measurable results; sometimes resulting in inefficiency and lack of responsiveness to address IT concerns due to lack of resources and financial constraints.

In terms of IT, UMC leadership faces an environment that is both complex and unique. This challenge is currently being handled at an adhoc level with no measurable results; sometimes resulting in inefficiency and lack of responsiveness to address IT concerns due to lack of resources and financial constraints. In our review, we determined there is a need to implement better internal controls to manage the current IT infrastructure (people, processes and technology) for the following areas to meet HIPAA security control requirements:

- Risk assessment
- Currency of policies and procedures
- Workstation security
- Encryption
- Configuration management
- Contingency planning

Risk Assessment - 164.308(a)(1) under [§164.308(a)(1)(i)] and [§164.308(a)(8)]
UMC has not conducted an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI) held by UMC.

The HIPAA Security Rule requires Covered Entities (CEs) such as UMC to conduct a risk assessment to identify risks and vulnerabilities to ePHI.

We observed the following conditions:

- UMC did not perform a risk assessment.
- UMC did not have a formalized, documented risk assessment process.
- UMC has not conducted a documented analysis targeted at risks to the confidentiality, integrity, and availability of ePHI.

UMC should develop and formally document a policy requiring the completion of a periodic risk assessment encompassing all IT systems and applications which store, process, or transmit ePHI. UMC should categorize its systems into General Support Systems

Our recommendations for the Hospital are as follows:

- UMC should develop and formally document a policy requiring the completion of a periodic risk assessment encompassing all IT systems and applications which store, process, or transmit ePHI. UMC should categorize its systems into General Support Systems (e.g., Local Area Network) and major applications (e.g., MEDITECH). The policy should require that such risk assessments be completed at least every three years, or whenever there is a significant change in the environment, including, but not limited to:
  - Introduction of new systems.
  - Significant upgrades to existing systems.
  - Retirement or disposal of systems.
  - Physical relocation of IT assets.
  - Introduction of new lines of business.
  - Reorganization of the UMC's management or business structure.

UMC must also identify components which handle ePHI and the physical location of IT assets that contain ePHI. Lack of an accurate inventory of systems and an understanding of business use of ePHI will prevent the UMC from establishing an effective risk assessment process

- UMC should develop and formally document supporting procedures for conducting risk assessments. One of the key initial steps in the risk assessment process is to identify the systems which store, process, or transmit ePHI. UMC must also identify components which handle ePHI and the physical location of IT assets that contain ePHI. Lack of an accurate inventory of systems and an understanding of business use of ePHI will prevent the UMC from establishing an effective risk assessment process.
- After UMC has an accurate inventory of systems and an understanding of the business use of ePHI, UMC should develop procedures outlining steps to:

- Identify the criticality of the system and its data.
- Identify threats to the system.
- Identify vulnerabilities on the system using manual and automated tools.
- Analyze the controls that have been implemented, or are planned for implementation.
- Identify the probability that a vulnerability may be exploited.
- Identify the impact of a successful threat exercise.
- Assess the level of risk.
- Identify additional controls to mitigate identified risks.
- Document the results of the risk assessment.

UMC should conduct a thorough baseline assessment of its IT infrastructure to ensure it can meet the meaningful use requirements to support Electronic Health Record (EHR)

UMC should conduct a thorough baseline assessment of its IT infrastructure to ensure it can meet the meaningful use requirements to support Electronic Health Record (EHR). At a minimum, this should include a review of current architecture, capacity, proposed upgrades and feasibility of implementation of a complete EHR to meet meaningful use requirements, including physical, technical and administrative controls.

Currency of Policies and Procedures - 164.308(a)(1) under [§164.308(a)(1)(i)] and [§164.308(a)(8)]

During our review, we identified compliance issues with currency of IT policies and procedures. We observed the following conditions:

- UMC did not document evidence of their review and approval of policies and procedures.
- UMC failed to provide any current IT policies and procedures.

Our recommendations for the Hospital are as follows:

- UMC should develop and formally document a policy requiring that management periodically review policies and procedures. This policy should outline the maximum timeframe between reviews as well as require management review when there is a significant change to systems or the environment.
- UMC should develop and formally document a procedure for conducting periodic reviews of policies and procedures. This procedure should allow management to conduct these reviews in a timely manner, which would be compliant with UMC's already documented policy for frequency of this type of review. The process should outline the steps for management to:
  - Identify policies and procedures for which they are responsible for reviewing.

- Gather the most recent versions of these policies and procedures.
- Assess the currency of the documented policy or procedure against the organization's operational and regulatory environment.
- Implement updates to the policy or procedure as necessary.
- Document evidence of their review and approval.
- Disseminate the updated policy or procedure throughout UMC.

Workstation Security – [§164.310(c)]
During the reviews, we observed the following conditions:

- UMC did not have a formalized, documented policy or process for verifying the security of workstations; and
- UMC did not deploy the necessary tools to implement workstation security.

In order to increase compliance with the Security Rule, the following solutions are recommended:

- Use benchmarks such as FDCC to secure workstations; and
- Run vulnerability scans to ensure the workstations are configured for security.

Encryption - [§164.312(e)(2)(ii)]
During the reviews, we observed the following conditions:

- Encryption was not implemented on all workstations and laptops.
- Encryption was not implemented on the transmission of data which contained ePHI.

In order to increase compliance with the Security Rule, the following solutions are recommended:

- Implement a mechanism to encrypt and decrypt electronic protected health information.
- Require that all portable or remote devices that store ePHI employ encryption technologies are of the appropriate strength.
- Deploy policy to encrypt backup and archival media; ensure that policies direct the use of encryption technologies of the appropriate strength.

Failure to establish an accurate inventory will results in the lack of assurance that UMC has encrypted all devices which require this protection.

UMC should develop an accurate inventory of laptops, workstations, and other portable devices or media. Failure to establish an accurate inventory will results in the lack of assurance that UMC has encrypted all devices which require this protection. Maintenance of this inventory should be integrated with the procurement process for new systems and devices.

Configuration Management - § 164.308
During the reviews, we observed the following conditions:

- UMC did not have a documented configuration management plan.
- UMC did not have documentation to support configuration changes in the General Support Systems and Major Applications.

In order to increase compliance with the Security Rule, the following solutions are recommended:

- Develop an Information Technology Infrastructure Library (ITIL) based configuration management process.
- Consider outsourcing configuration management to an ITIL based third-party vendor that provides complete configuration management of the enterprise in conjunction with other automated tools such as Ecora, Patchlink, etc.

Contingency Planning - 164.308(a)(7) under [§164.308(a)(7)(i)]
During the reviews, we observed the following conditions:

- Even though backups were being done on tape, there was no agreement for hot/cold site for contingency and or disaster recovery.
- We were unable to review existing Contingency/Disaster Recovery Plans for UMC.

In order to increase compliance with the Security Rule, the following solutions are recommended:

- Develop a comprehensive Contingency/Disaster Recovery Plan.
- Finalize arrangements with a Service Continuity Provider.
- Test the reliability of the backup media to restore critical assets.
- Consider outsourcing function to a reputable service provider.

Additional recommendations for the Hospital are as follows:

We recommend UMC leadership establish a security mission within UMC, and establish goals to fulfill such mission.

Executive management should stress the importance of information security and emphasize the need to comply with HIPAA security, meaningful use, and other requirements.

UMC management is responsible to ensure its IT Department has accurate maps, detailed directions, and, most importantly, that all teams are communicating and working together to reach common goals. The need for assurance about the value of IT, management of IT related risks and increased requirements for control over information are now understood as key elements of enterprise governance. Business IT strategic alignment, IT value delivery, IT risks management, IT resource management and IT performance management, constitute the core of IT Governance. It is the responsibility of management for leadership, and establishment of organizational structures and processes that will ensure UMC's IT sustains and extends the organization's strategy and objectives.

We recommend UMC leadership establish a security mission within UMC, and establish goals to fulfill such mission. Executive management should stress the importance of information security and emphasize the need to comply with HIPAA security, meaningful use, and other requirements, from that point forward. We recommend implementation of the following:

- Adequately staff the IT workforce for long term sustainment. We do not believe current staffing is adequate to meet UMC's needs. We observed single point of failures due to insufficient staff (staff of 6 supporting all major applications and general support systems).
- Adopt a framework for IT Governance and continuously monitor internal controls to ensure UMC is complying with increasingly stringent regulations set forth by Federal agencies, including E-government Act (FISMA), FFMIA (OMB A-123) and other Federal and District requirements. The framework at the minimum should include provisions for UMC to:
    - Plan and organize
    - Acquire and implement
    - Deliver and support
    - Monitor
- Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary, and correct identified security deficiencies as part of its risk management process to ensure compliance with meaningful use requirements for EHR (including bio-medical devices).
- Encrypt data stored on portable media.
- Consider implementation of two-factor authentication, which is a security process in which the user provides two means of identification. Typically, this requires a physical token, such as a

card, and something memorized, such as a security code (i.e., "something you have and something you know").

- Review requirements for Personal Identity Verification (PIV) (HSPD-12) compliance and consider planning to meet the set objectives. For example, for physical and logical access controls, using smart cards with PKI encryption.
- Conduct vulnerability assessments using automated tools to protect IT systems from common threats and vulnerabilities. Such tools include GFI Languard, Nessus and others.
- Implement and/or outsource configuration management (e.g., using a service provider to support configuration management activities in conjunction with implementation of tools such as Ecora, Patchlink, etc.).
- Finalize Contingency and Disaster Recovery arrangements with an external vendor, update the configuration management plan and test the contingency/disaster recovery plan at the cold/hot site.

We emphasize that unless these steps are taken to improve UMC's IT security, the Hospital would not be eligible for incentive payments under the Patient Protection and Affordable Care Act.

We emphasize that unless these steps are taken to improve UMC's IT security, the Hospital would not be eligible for incentive payments under the Patient Protection and Affordable Care Act. Such incentive payments could be as great at $2 million. Prior to employing any software to implement an EHR system, a requirements assessment encompassing the above recommendations must be conducted. Our recommendations provide the framework to establish a comprehensive EHR system.

Patient Billing & Collections

The accounting and finance staff of the Hospital are a mix of direct hospital employees, OCFO employees, and contractual employees. The accounting and finance staff include PFS. The PFS Department performs a variety of billing and financial services. Their most important function is timely and accurate billing of Medicaid, Medicare, patients, and other third-party payers, including commercial insurers. Operationally, PFS has four teams and each team solely manages claims for patients insured by Medicare, Medicaid, Commercial and Managed Care Organizations (MCOs).

Each team is responsible to ensure claims generated from all service lines of the Hospital are prepared and screened for accuracy, validity, completeness, and meets the established billing guidelines. UMC utilizes the MEDITECH billing system. Each team researches their assigned claims, retrieves the missing information, makes needed corrections, and prepares the claims to be processed. Based on our observation, it appears these processes are aligned with the team's work process rather than the billing goals of the department.

Overall, it was apparent in our observations and discussions with members of the PFS staff there was a lack of clarity regarding the correlation of each employee's role and responsibilities with the overall financial operations of the Hospital, as well as the lines of management oversight, authority, and responsibility.

According to our discussions with UMC Executive Management, PFS staff, medical coding staff, and members of various clinical departments, the PFS director role had been vacant for a number of months.

Overall, it was apparent in our observations and discussions with members of the PFS staff there was a lack of clarity regarding the correlation of each employee's role and responsibilities with the overall financial operations of the Hospital, as well as the lines of management oversight, authority, and responsibility. This is partially attributed to the lack of formal documentation and communication of roles, responsibilities and authority. While some policy, process and control documentation exists, it is severely lacking in detail and breath, especially as it relates to the coordination between the OCFO employees, hospital employees, and contractual employees. In addition, for most of our time on-site during August 2011, there was a lack of overall coordination between departments to completely capture services provided in clinical departments, ensure the accuracy of the medical coding, oversee the preparation of patient bills and follow-up on incomplete and/or denied claims, and to ensure the information was flowing between pertinent departments without error or data loss. According to our discussions with UMC Executive Management, PFS staff, medical coding staff, and members of various clinical departments, the PFS director role had been vacant for a number of months. We did note that by early September 2011, a consultant had been hired to perform this function.

Within each of the subheadings below, we provide more specific detail of the matters noted in our evaluation of patient billing and collection internal controls. Such matters related to the areas of policy and procedure manuals, charge entry, charge master, coding, claim monitoring, uncollectible patient receivables, and charity care.

PFS Policy and Procedure Manuals

UMC's Billing Manual (last revision November 14, 2008) was reviewed through inspection of the paper document, as well as interviews with the PFS staff. Typically, the processes outlined in such manual include initial submission and re-submission billing procedures for all vendors who provide services to UMC. Additionally, narratives should be clear, and step-by-step procedures should be accompanied by examples of reports or documents referenced in the narrative.

It is imperative that the billing manual covers the policies and procedures for processing such payments.

Revenue resulting from billing activity comes into PFS in the form of checks and wire transfers from various sources. These checks are recorded and processed by a cash poster, who is a member of the PFS staff. It is imperative that the billing manual covers the policies and procedures for processing such payments.

We found the manual to be deficient in the following areas:

- No examples of referenced documents. The manual is a guide and reference document which should contain pictorial and step-by-step narrative instructions for all staff to easily follow. It facilitates cross-training of staff, and serves as a guide for new employees attempting to understand the process.

- The narrative in the “Processing Claim Rejection” section found on page 37, lacks clear step-by-step instructions.
- The manual does not contain a process flowchart.
- The Cash Posting Policies and Procedures Manual appeared to be out of date versus current cash posting procedures, and, in our opinion, were not easy to follow.
- There is no cash posting compliance plan available.

Our recommendations for the Hospital are as follows:

- Billing Manual should be revised to include screen shots and copies of important documents which are part of the process. The billing manual is designed to facilitate an understanding of the billing process. As such, it should contain visual aids of the myriad documents and screens an employee will encounter as he/she engages in the billing process. It must also reflect best practices associated with claims billing.
- Resubmission of denied claims and correction of errors is an important aspect of the billing process, and it constitutes the bulk of the PFS staff responsibility. Hence, greater detail and process flowcharts are needed to add clarity, and to provide a clear understanding of the process.
- The Cash Posting Policy and Procedure Manual must be revised to show clear step-by-step procedures which can be easily followed.
- A written Cash Posting Compliance Plan must be developed and available to demonstrate proper controls have been established to oversee the appropriate recording of all payments received by the Hospital. Note: The PFS department has one (1) cash poster on site who is currently supervised by someone offsite (in another state). This employee comes to UMC once per month to meet with the UMC staff to reconcile reports.

A written Cash Posting Compliance Plan must be developed and available to demonstrate proper controls have been established to oversee the appropriate recording of all payments received by the Hospital.

We also evaluated the Billing Manual for its effectiveness to encourage compliance with established regulations, regarding fraud, waste and abuse. According to a CMS “Compliance Program Guidance” publication in 2005, “CMS believes that compliance efforts are fundamentally designed to establish a culture within an organization that promotes the prevention, detection and resolution of instances of conduct that do not conform to federal and state law, or to federal healthcare program requirements.”

We requested from PFS a written compliance program, and received a “UMC HIPAA Privacy and Security Departmental Self Assessment” document, which was not designed to address the functions and responsibilities of the department. A review of the Billing Manual

shows four requirements, which may constitute the framework for a compliance program. They are as follows:

The biller shall:

- Understand the Medicare Fraud and Abuse Guidelines and penalties for submitting false claims.
- Understand that his/her work will be reviewed periodically for compliance with the Hospital's policy on business practices, as well as adherence with PFS policies and procedures.
- Report overpayments immediately to his/her supervisor for corrective action in accordance with the Hospital's established policy on business practices.
- Report any suspected or known wrong-doing to the Department Director or Compliance Officer, in accordance with the Hospital's established policy on business practices.

A lack of adequate internal controls and compliance creates an environment that is susceptible to waste, fraud and abuse.

The above-mentioned requirements may form the basis for a billing compliance program; however, there is much work required to ensure an adequate control environment for this department. In addition to the highly quantitative nature of department's daily billing operation, there is a cash posting function for which we were unable to obtain satisfactory evidence of a compliance process or validate the adequacy of the control environment. A lack of adequate internal controls and compliance creates an environment that is susceptible to waste, fraud and abuse.

Our recommendation for the Hospital is as follows:

- Develop an effective compliance program, tailored to measure, test and monitor specific areas of the billing and cash posting, which present the greatest risks for fraud, waste and abuse. The program should include the following basic elements:
    - Written compliance policies and procedures.
    - Formal and informal training for new and existing employees.
    - Formal policies for approval and oversight.
    - Hotline or other System to report suspected non-compliance.
    - Auditing and monitoring procedures.

Charge Entry

Clinical departments should review revenue reports on a periodic basis (weekly) and investigate/resolve variance from expectations. We noted this practice has been recommended to the clinical departments by the finance office; however, no consistent practice is in place to ensure that departments are monitoring charges.

There is a significant issue with entering sterile processing and delivery (SPD) charges and supplies for operating room (OR) procedures, and labor and delivery services.

This "hold" pile is significant and has been accumulating for a number of months. The pile accumulates on a rolling 2 to 3 month basis.

There is a significant issue with entering sterile processing and delivery (SPD) charges and supplies for operating room (OR) procedures, and labor and delivery services. Charge sheets, which are listings of charge codes by procedure completed by clinical personnel, are delivered to PFS from the department providing the services and completing the charge sheet. At the time that PFS enters charges into the billing system (MEDITECH), the system verifies the charge against current inventory levels, and often rejects the charge entry. In these instances, PFS contacts the applicable clinical department director and the Controller about the issue. The charge sheet is placed in a "hold" pile until acted upon. This "hold" pile is significant and has been accumulating for a number of months. The pile accumulates on a rolling 2 to 3 month basis. An unbilled SPD charge sheet is typically under $100, while charge sheets including SPD charges and medical charges are typically in excess of $1,000. As such, it is difficult to estimate an amount of this pile, given its churn rate and charge mix at any given point. Once the charges are entered, the 4-day bill hold pre-established in MEDITECH has lapsed, and the charges appear as 'late charges' on the patient bill.

All charges should be entered and applied to patient accounts in MEDITECH by the clinical departments instead of PFS, and charges should be reviewed and approved by a Charge Nurse to verify completeness and accuracy. This would provide each clinical department greater ownership and accountability to ensure that charges have been captured and billed. Reconciliations should be performed by PFS between charge sheets and batch journal entries posted to the Hospital's general ledger to ensure the completeness, existence, and accuracy of charges entered and revenue recognized.

Our recommendations for the Hospital are as follows:

- Establish a routine process for clinical departments to receive revenue reports on a monthly basis and investigate/resolve variances from expectations.
- Establish procedures whereby clinical departments capture sterile processing and delivery (SPD) and supply charges in MEDITECH to increase accountability and billing accuracy.
- Implement a procedure to reconcile charge sheets to batch journal entries posted to the Hospital's general ledger.

Chargemaster

We were unable to ascertain the last time the chargemaster was reviewed and/or updated.

The chargemaster, which is the database containing all costs by procedure code that interfaces with BAR to apply the charge to a patient's bill, should be reviewed on a periodic basis for accuracy, and changes (additions, deletions) and/or price adjustments should be reviewed and approved prior to updating the chargemaster. We were unable to ascertain the last time the chargemaster was reviewed

and/or updated.

Our recommendation to the Hospital is as follows:

- Establish procedures to routinely update the chargemaster to ensure it is current at all times.

Coding

Per discussion with PFS personnel, there are opportunities to increase reimbursement if a patient is morbidly obese per their body mass index (BMI). However, BMI is often not tracked by the physicians and thus opportunities for higher reimbursement are missed.

Incomplete charts or missing diagnosis information results in patient files being placed 'on-hold' in the Health Information Management department, and the patient designated as "discharge not final billed" in the billing system. The Hospital has a process in place to monitor these billings, but greater cooperation by clinical personnel could help reduce the on-hold items to a more acceptable level. The Hospital's goal is to keep the discharge not final billed activity below $500,000. We were informed by PFS staff that the activity typically ranges from $400,000 to $600,000, and has peaked at high as $800,000.

Our recommendations for the Hospital are as follows:

- Ensure care providers are capturing all critical aspects of patient acuity and services provided to maximize reimbursement.
- Enhance communication amongst PFS, clinical personnel and medical records personnel in an effort to further minimize 'on-hold' billings.

Claim Monitoring

Medical Records Department (MRD) and PFS staff were interviewed to identify established processes that ensure the timely and accurate filing of denied claims. We also analyzed denied Medicaid claims for fiscal year 2010 (see the "Medicaid Claims Review" section of this report) and evaluated the current practice for processing a remittance advice (RA), which is a patient-by-patient listing of payments and denials provided by third-party payors.

Based on our interviews and verbal reference to processes, there appears to be a lack of communication between the two departments following the arbitration of claims.

MRD provides coding for claims (DRG- Diagnosis Related Group) based on the review of the medical records. This coding is used in the billing to all third-party payors. MRD uses a 3M encoding system to create the codes for billing. The codes are passed to PFS claim negotiation. Based on our interviews and verbal reference to processes, there appears to be a lack of communication between the two departments following the arbitration of claims. Under the current work flow, it is PFS that must address the post-adjudication issues related to the claim. One tool utilized by PFS is RAs. RAs are scanned for denials, which are required to be subsequently researched, corrected and promptly resubmitted for payment. It is our

understanding the MRD does not actively participate in such post-adjudication processes.

MRD's inability to communicate expeditiously regarding the status of claim creates the potential for inaction on denied claims. At an operational level, MRD lacks the information to measure its own performance. This business process allows opportunity for erroneous DRG's to be created in the MRD, which may result in a high level of denied claims.

Based on interviews and analysis, the following was determined:

- Medicaid, along with most of its vendors, allow a 90 day time period after date of service for an initial bill to be transmitted, and 45 days after denial for a claim to be re-billed. If claim status is not shared with the MDR in a timely manner, revenue is lost.
- It is the objective of the PFS to submit clean/accurate claims the first time. However, accuracy is dependent on many variables (i.e., patient information, changes in coverage, correct coding and clinical information, etc.) which affect the claim's ability to be adjudicated on its first submission.
- Each claim needs be tracked until fully adjudicated, or eventually adjusted. We were unable to identify a compliance plan to ascertain that this monitoring occurs on a regular basis.
- The claim resubmission process followed by staff varies significantly from the steps identified in the billing manual.

Our recommendations for the Hospital are as follows:

- Revise the Billing Manual to reflect current billing and re-submission practices.
- Cross walk current billing procedures against established industry standards and best practices.
- Teams should periodically review denied claims to understand reasons for over/ underpayment, and ensure that every efforts were made to fully adjudicate a claim.
- Establish a mechanism for the MRD to expeditiously review the status of claims submitted and reason for denial. An expeditious review process should consider the recoding of denied claims by a secondary review of paper records. This process will include review of medical charts for supporting documentation and will ensure each clinical department is actively involved and accountable for achieving the billing goals of the Hospital.

There is an overall lack of awareness of the protocol prescribed in the Hospital's policies and procedures.

The Hospital should consider utilizing a third-party vendor under a contingent fee arrangement to pursue collection of aged receivables, which we believe will increase cash inflows.

Assessment of Uncollectible Patient Receivables

During our discussions with various accounting and finance personnel, we noted varying responses regarding permission to approve the write-off of uncollectible patient receivables. There is an overall lack of awareness of the protocol prescribed in the Hospital's policies and procedures.

The "Bad Debt Write-off Policy" states that aged accounts are placed with a collection agency for pursuit of payment. The policy further describes the procedures for the use of collection agencies. However, the Hospital currently is not utilizing a collection agency and does not appear to aggressively pursue collection of self-pay balances. The Hospital should consider utilizing a third-party vendor under a contingent fee arrangement to pursue collection of aged receivables, which we believe will increase cash inflows.

The Hospital recently started reviewing underlying assumptions used in its allowance for doubtful accounts and contractual allowance calculations. The review is primarily a 'look-back' exercise that is performed monthly to assess whether the percentages used by payor, aging bucket, etc. are reasonable. However, no adjustments to the calculations have been made as a result of the look-back analysis.

There is no specific identification of accounts to reserve, and certain balances are automatically reserved at 100% without further analysis. For example, self-pay and professional fee receivables are automatically reserved at 100%.

During our discussions with accounting personnel, it was asserted that the overall level of analysis performed over the allowance for doubtful accounts and contractual allowance calculations can be significantly improved given the sensitivity and materiality of the estimates.

Our recommendations for the Hospital are as follows:

- Ensure established protocol with respect to write-off of uncollectible patient receivables is consistently followed.
- Aggressively pursue delinquent patient accounts by leveraging a collection agency, as necessary.
- Increase scrutiny over the evaluation of the adequacy of allowance for uncollectible patient accounts and contractual allowance reserves. Application of the Hospital's policies should not be overly aggressive or conservative.

There is an overall lack of awareness of the protocol prescribed in the Hospital's procedures.

Charity Care

During our discussions with various accounting and finance personnel, we noted varying responses regarding approval for charity care applications. There is an overall lack of awareness of the protocol prescribed in the Hospital's procedures. The Admissions Department acknowledges its responsibility to complete, review and approve

applications; however, they believe final approval is the responsibility of the accounting and finance department. Accounting and finance believes the process rests solely with admissions.

We recommend that executive management ensure established protocol with respect to approval of charity care is consistently followed.

Medicaid Claims Review

In our analysis of the adjudicated claims, we determined that paid claims in the same remittance cycle included duplicate claims. Hence identical claims were both paid and denied on the same submission. Approximately 2,284 denied claims, out of over 5,000 claims, were subsequently resubmitted and received payment.

Denied claims were analyzed to identify the most common reasons for denial.

Denied claims were analyzed to identify the most common reasons for denial. The following list constitutes the top 5 reasons for denial:

1. Exact duplicate claim.
2. Category of services cannot be determined.
3. Missing or invalid prior authorization number.
4. Missing or invalid admission source or information.
5. Services covered by HMO.

Additionally, $97,252 of charges was denied for exceeding the timely filing limit.

We were unable to confirm that UMC maintains a formal documented plan for rebilling denied claims. From our interview with PFS staff, we estimate 1/3 of the denied claims are re-billable. Continuous denial of allowable claims has put a strain on UMC's cash flow.

We obtained UMC Medicaid claim submission data from DHCF for fiscal years 2010 and 2011. The claim data was combined to reflect Medicaid services billed by UMC from January 1, 2010 through December 31, 2010. The claim data was organized into billed, paid and denied categories, with subcategories for additional claim data and identification of duplicate claims. Using key fields such as patient ID, billed amount and discharge date, we were able to segregate the data into multiple categories for analysis.

Our review of the claims submitted for the above stated time period revealed that UMC billed its Medicaid claims using four (4) Provider Identification Numbers. These are United Medical Center (1), Not For Profit Hospital Corporation (2) and one United Medical Nursing Center (1). The claim review was restricted to inpatient and outpatient

Medicaid claims, and excluded Medicare/Medicaid crossover and duplicate claims.

The largest number of claim transactions was conducted through UMC provider identification number, which consisted of $42 million in billed charges.

It does not appear based on our review that UMC staff is consistently rebilling accurately for denied claims. This represents a lost opportunity for increased revenue.

For the stated service period, we reviewed $63 million in claims. Of these claims, $4.1 million were duplicate claims. Of the remaining $58.9 million in claims, $13.9 million, or 24%, were paid, and $4.3 million accounted for denials. The remaining $40.7 million were estimated adjusted claims. It does not appear based on our review that UMC staff is consistently rebilling accurately for denied claims. This represents a lost opportunity for increased revenue.

Inpatient and Outpatient Data

We reviewed the Medicaid inpatient and outpatient claim data for the Hospital. Inpatient services are the highest component of revenue billed to Medicaid with $37.6 million in claims. For analysis purposes and consistency, payments for Medicare/Medicaid crossover claims, patient responsibility and third-party liability claims were excluded.

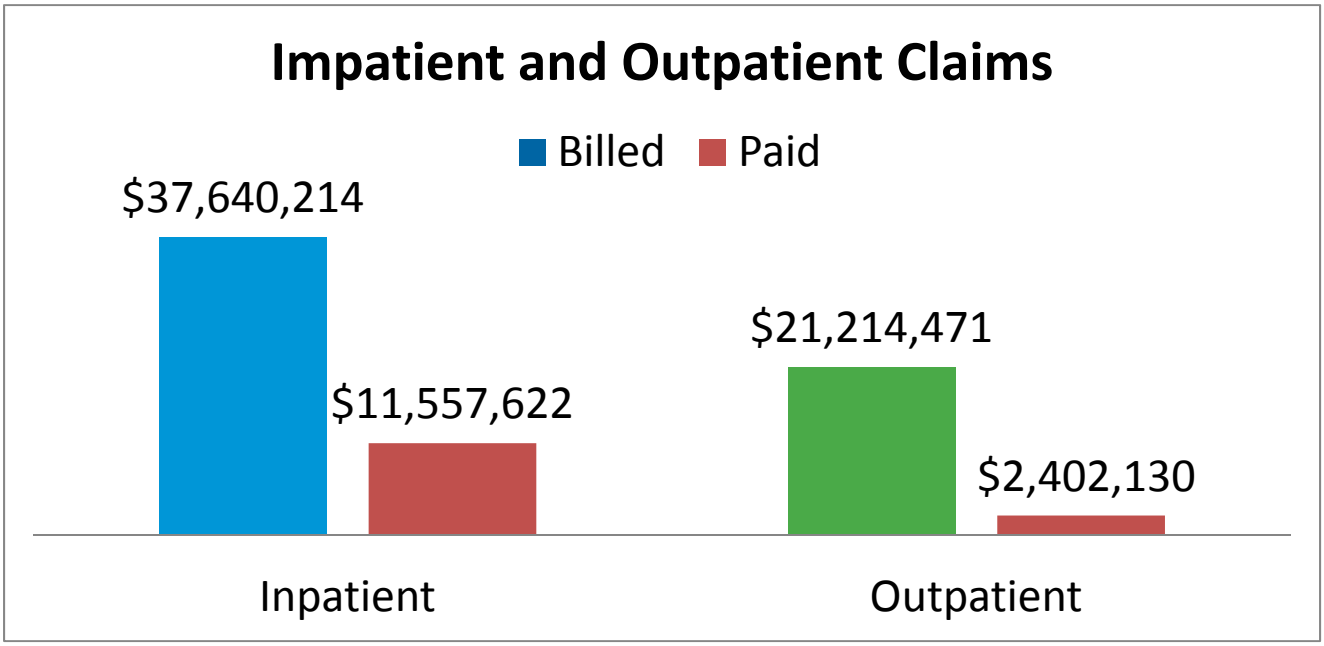

Figure 1. Inpatient and Outpatient Claims

Our recommendations for the Hospital are as follows:

- UMC should conduct a gap analysis and take steps to review the claim coding operations. Emphasis should be placed on establishing a comprehensive compliance plan, involving all stakeholders (i.e., Management, MRD and PFS), for creating claims and resubmitting denied claims.

- Consider engaging an independent data mining technology consultant to conduct an analysis of hospital claim data Medicaid and Medicare databases to identify potential billing of previously denied claims and/or charity care. Providers are currently performing similar services at Howard University and George Washington Hospital in the District.
- Improve communication between PFS and MRD to reduce coding errors and increase rebilling of denied claims.
- Employ a collective and an effective management communication structure that places importance on a sustainable cash flow, improved accountability for the submission of successful claims, and maximizes the collections from third parties.

Acquisition, Depreciation and Disposal of Property & Equipment

The Asset Capitalization Policy provided to us includes policies for the construction of recreation courts, athletic fields, and swimming pools.

The Asset Capitalization Policy provided to us includes policies for the construction of recreation courts, athletic fields, and swimming pools. It did not appear to be appropriately tailored to be specifically applicable to the Hospital. We also noted the Capital Expenditures Policy provided to us was likely not updated to incorporate the procurement policies under the District of Columbia Home Rule Act, as the policy was dated April 2008.

The Hospital does not maintain a detailed subsidiary property and equipment ledger for assets acquired prior to July 9, 2010. We also noted there is no ongoing process performed by the accounting and finance department to monitor for triggering events of potential impairment, or to perform impairment analysis when triggering events are present.

Assets existing upon assumption of the Hospital by the District were recorded as a lump-sum based on the fair value assessment performed by a valuation specialist. The fair value of this grouping of assets was $60 million at July 9, 2010. The Hospital budgets an annual depreciation expense for this grouping of assets. This methodology does not allow for the proper disposal of individual assets or assessment of impairment. In addition, such methodology adversely affects the accuracy of the reported depreciation expense. The appraisal report included a full asset-by-asset detail, which could have been used to create a subsidiary property and equipment ledger in MEDITECH.

Acquisitions and disposals subsequent to July 9, 2010 are tracked asset-by-asset on a spreadsheet outside of the accounting system. The activity is manually posted to the general ledger through a monthly journal entry. The spreadsheet is stored on a shared network drive, and all individuals with access to the network drive can access the

spreadsheet. The spreadsheet is not password protected and the cell calculations are not protected.

In addition, the Hospital has no established process to physically count, either perpetually or periodically, its property and equipment to validate the accuracy of amounts reported in its annual financial statements.

Bio-medical Engineering and Building Services departments maintain listings of equipment for purposes of tracking location, transfers between clinical locations, service and maintenance requirements, warranties, and work orders. However, such equipment listings are not reconciled to the property and equipment spreadsheets used by accounting to support the amounts reported in the Hospital's annual financial statements. In addition, the Hospital has no established process to physically count, either perpetually or periodically, its property and equipment to validate the accuracy of amounts reported in its annual financial statements.

Our recommendations for the Hospital are as follows:

- Tailor the asset capitalization policy to be more specifically applicable to UMC's operations.
- Utilize the subsidiary property and equipment ledger feature of MEDITECH to maintain a more secure, reliable and accurate database of all property and equipment of the Hospital.
- Establish procedures to periodically inventory property and equipment of the Hospital.
- Establish procedures to assess potential impairment of property and equipment.

Inventory, Procurement, Accounts Payable and Cash DIsbursements

The department uses a manual card system to track supplies and pharmacy inventory. This manual process is much less efficient and prone to errors. In discussions with clinical department staff, we noted complaints regarding the overall availability of supplies.

The Materials Management department, which is responsible for ordering and receiving general and SPD supplies for all components of the Hospital, does not rely on the inventory usage thresholds defined within MEDITECH. This feature of MEDITECH has the ability to notify the department when ordering is necessary and the quantities that should be on-hand. The department uses a manual card system to track supplies and pharmacy inventory. This manual process is much less efficient and prone to errors. In discussions with clinical department staff, we noted complaints regarding the overall availability of supplies.

The creation of a "Product Evaluation & Standardization Committee" was in the discussion phase while we were on-site at the Hospital. The goal for this Committee would be to review inventory items and related contracts to identify vendors, evaluate alternate products, negotiate pricing, and more. Prior to the creation of the Committee, no formal process existed at the Hospital. The Committee is in its infancy stage and it is too early to determine its effectiveness.

There should be at least two approvals required for each PO.

All purchase orders (PO) must be approved by the Materials Management Director, but no other approvals are required. There should be at least two approvals required for each PO. Typically, POs would be approved by an authorized manager in the requesting department and a supervisor level in accounting and finance. In addition, the individual responsible for pharmaceutical purchasing is the same individual responsible for receiving and verifying agreement between ordered and received quantities. This results in the lack of proper segregation of duties.

The semi-annual physical inventory count of supplies is limited to the general storeroom, pharmacy, OR, and emergency room departments. There is no physical inventory count performed in any other clinical departments.

Once an inventory item is issued from the general storeroom to a clinical department, the item is automatically expensed to that department. A physical count in each clinical department should be performed on a monthly basis to adjust expenses charged to each department for inventory quantities still on-hand.

Our recommendations for the Hospital are as follows:

- Utilize the inventory usage threshold features of MEDITECH to better manage inventory needs and increase accuracy of patient billings for SPD and supplies.
- Ensure proper segregation of duties for requesting and verifying receipt of goods and services.
- Formally evaluate the effectiveness of the Product Evaluation & Standardization Committee, and ensure related recommendations and action plans are implemented, evaluated for effectiveness, and adjusted as necessary.
- Ensure all departments with more than nominal amounts are included in the semi-annual physical count of supplies.
- Ensure expenses charged to each department are adjusted for inventory quantities on-hand.

Payroll

Overall, based on our understanding of the key processes and controls related to the payroll transaction cycle, internal controls in this area appear to be adequate.

Overall, based on our understanding of the key processes and controls related to the payroll transaction cycle, internal controls in this area appear to be adequate. We did note the following matters for UMC's consideration:

- Consistent with the other transaction cycled we evaluated, we recommend UMC formally document SOPs for this transaction cycle, as payroll is one of the most significant expense of the Hospital.

- In our test sample of 12 UMC employees, we noted the Human Resources (HR) file for two Registered Nurses (RNs) contained expired RN licenses. We further noted a significant back-log of RN licenses to be filed. We recommend UMC ensure HR files contain current licenses for all personnel requiring a professional license to perform their duties.

Identification and Monitoring of Loss Contingencies

We obtained a litigation summary from UMC's in-house counsel, which was considered to be a complete listing of all current litigation directly or indirectly affecting the Hospital. The listing contained nine cases involving vendor disputes, mostly for breach of contract. The Not-for-Profit Hospital Corporation was not named in three of the nine cases. For the cases in which UMC was named, the exposure documented in the list could be as high as approximately $1.5 million. The listing also contained three medical malpractice cases with very brief status notes. The listing indicates the three cases are covered under insurance policies.

The Hospital does not have formal documented policies and procedures related to insurance coverage requirements, settling claims, or recording malpractice, general liability and workers compensation reserves.

The Hospital does not have formal documented policies and procedures related to insurance coverage requirements, settling claims, or recording malpractice, general liability and workers compensation reserves. We inquired of various hospital personnel in gaining an understanding of processes and controls related to professional and general liability activity. During these discussions, we noted a general lack of coordination among departments. For example, the Accounting and Finance Department place reliance on the Risk Management Office for tracking claims, and is unaware that the Risk Management Office has limited procedures established. Questions asked of accounting and finance personnel specific to accounting and/or financial reporting were deferred to the Risk Management Office (e.g., is an actuary utilized, in which general ledger account is the loss reserve liability recorded, is a formal IBNR analysis performed?).

The Hospital does not maintain a claim/incident log that tracks potential claims, asserted claims, closed claims, or claims being actively defended.

The Hospital utilizes a Risk Occurrence Form to report potential claims activity to the Risk Management Office. Hospital personnel are instructed to complete these forms for events such as safety violations, potential malpractice, and falls on hospital grounds, etc. The forms are evaluated by the Risk Management Office, and a determination is made whether it is necessary to forward the information to the Hospital's third-party claims administrator.

The Hospital does not maintain a claim/incident log that tracks potential claims, asserted claims, closed claims, or claims being actively defended. Risk Occurrence Forms are not maintained in an orderly or systematic manner to enable a review and analysis by the

Risk Management Office. Also, the Risk Management Office does not formally track incidents reported to the third-party claims administrator, though the office is generally aware of the status of such incidents. The Hospital should be formally tracking the details of all incidents reported in a perpetual claim/incident log, including the most recent status, even if settled/closed.

However, the Hospital does not have a formal process established to receive routine reporting from the third-party administrator.

The third-party claims administrator maintains the Hospital's incident activity in an internal database. Reporting of claim activity can be extracted from this database and provided to the Hospital. However, the Hospital does not have a formal process established to receive routine reporting from the third-party administrator. The Hospital relies on the third-party administrator to monitor and manage all such claim activity. The Hospital should be requesting monthly status reports from the third-party administrator and reconciling that activity to a claim/incident log maintained by the Hospital's Risk Management Office.

Based on review of correspondence between the Risk Management Office, external counsel, and the third-party administrator, significant discrepancies were noted regarding cases the Hospital had engaged the external counsel to defend.

Based on review of correspondence between the Risk Management Office, external counsel, and the third-party administrator, significant discrepancies were noted regarding cases the Hospital had engaged the external counsel to defend. The Hospital had to request reconciliations from both the external counsel and third-party administrator of claimants assigned and professional services billed to the Hospital. It appears that the Hospital does not have a firm awareness of claims being handled by the companies it has engaged for professional services.

The Hospital requires that a "Root Cause Analysis & Action Plan" report be completed for any incidents deemed 'catastrophic' (i.e., incidents with a 4 or 5 rating, which indicates major or severe adverse occurrence, including death). This report is required to be completed by the associated clinical personnel; however, these reports are often completed by the Risk Management Office. The Risk Management Office informed us that the report results are sometimes discussed with departmental administrators, but are not required to be shared or formally implemented. The reports are ultimately filed with the Risk Management Office to satisfy regulatory requirements of TJC accreditation. We recommend a process be implemented to formally notify clinical personnel of findings and the resulting action plan, as well as to track progress toward accomplishing specific goals created within the action plan.

The Hospital does not have a process to formally evaluate claims/incidents and establish a loss reserve for unresolved activity.

The Hospital does not have a process to formally evaluate claims/incidents and establish a loss reserve for unresolved activity. The Accounting and Finance Department relies on the Hospital's attorneys to initiate communication and provide the amounts that should be reserved for claims being actively defended. By establishing a claim/incident log and actively managing the status of claim activity

with the third-party administrator and attorneys, the Hospital will have the ability to routinely establish a loss reserve. The assumptions and reserves should be formally analyzed on a monthly basis by the CFO and Risk Management Office to determine adjustments to the reserves. Based on the nature of services performed by the Hospital (ER, pediatric ER, labor and delivery, OR, etc), and taking into consideration that the Hospital has a $100,000 self-insurance retention (deductible), the Hospital has professional and general liability exposure and should have a loss reserve recorded. In the event that no exposure exists, the Hospital should be able to produce a formal analysis that supports such an assertion. Per inspection of the Hospital's trial balance as of June 30, 2011, we noted no loss reserve liability. We noted the Hospital directly expenses legal expenses and settlements when cases are settled or legal invoices received.

Our recommendations for the Hospital are as follows:

- Formally document policies and procedures related to insurance coverage requirements, settling claims, and recording malpractice, general liability and workers compensation liability reserves.
- Maintain a current and complete claim/incident log that tracks potential claims, asserted claims, closed claims, and claims being actively defended.
- Implement a formal process to evaluate claims/incidents and establish a loss reserve for unresolved activity.

  Ensure the effective use of Root Cause Analysis & Actions Plans to reduce claim exposure to the Hospital.

Monthly and Annual Closing Process, and Preparation of Financial Statements

Based on our observance of the accounting and finance department's month-end close for September 2011, we noted the existence of defined timetables for closing, along with a listing of reconciliations to be completed.

Based on our observance of the accounting and finance department's month-end close for September 2011, we noted the existence of defined timetables for closing, along with a listing of reconciliations to be completed. The preparation and review of the reconciliations were assigned by individual. We also noted the preparation and delivery of the month-end financial reporting package to Executive Management within the defined timeline. Lastly, we noted that the accounting and finance staff prepares GAAP financial statements, including all note disclosures.

In the report from the Hospital's independent auditors, dated March 24, 2011, deficiencies were reported related to the timeliness in preparing a complete set of financial statements, accompanied by appropriate supporting documentation. Based on our understanding, it appears that the Hospital has taken actions to address the timeliness of their financial reporting. We did not perform procedures to determine the

completeness and accuracy of the financial reporting package provided to Executive Management.

Based on our discussions with a variety of accounting and finance personnel, resources are limited for training and there is no budget for individuals to attend trainings or hospital-sponsored education to remain up-to-date on accounting pronouncements and other industry appropriate topics.

Completeness of Note Disclosures to UMC's Financial Statements

We obtained UMC's audited financial statements as of and for the period ended September 30, 2010. We reviewed the financial report to determine whether significant disclosures had been omitted from the notes to the financial statements. We performed the following procedures:

- Completed the "Health Care Providers Disclosure Checklist" obtained from Accounting Research Manager.
- Completed a "US GAAP Disclosure Checklist" obtained from Accounting Research Manager. We note while these checklists are not specific to governmental non-profit entities reporting under accounting standards issued by the Governmental Accounting Standards Board (GASB), we utilized the checklists because many of the disclosures requirements are identical for governmental and non-governmental entities. We considered any significant disclosure differences when completing the aforementioned checklists.
- Compared the disclosures within UMC's audited financial statements to those contained within similar client audited financial statements.

We recommend the Hospital consider the following potential disclosures:

- Potential liability and disclosure related to remediation of asbestos.
- Potential impairment to the carrying value of the assets held by UMC.
- Expansion of significant accounting policies, such as management use of estimates, revenue recognition of contributions and grants, income tax status, contractual allowances, and bad debt allowances.
- Recent accounting pronouncements and its impact, or anticipated impact, on UMC's financial statements, such as disclosure of charity care.

- Significant contractual commitments, such as licensing, preventative maintenance and other service contracts, and lease arrangements.
- Significant commitments and contingencies, such as regulatory investigations, if any, CMS Recovery Audit Contractor program, regulatory environment including fraud and abuse matters, and the Patient Protection and Affordable Care Reconciliation Act.
- Details of disproportionate share activity.
- More robust disclosures regarding general liability and professional liability and workers compensation insurance coverage and activity.

During our tour of the Hospital, we noted numerous locations within the building where 9”x 9” tile was present. This specific tile is widely known for the presence of asbestos. In its completely installed state, the tiles pose no threat of asbestos exposure. Only in the case of significant damage to the tile and adhesive material, or complete renovation of the tile, would the asbestos be exposed. Per discussion with the Facilities Director, as areas of the Hospital have been renovated, the 9” x 9” tile was directly covered with a new layer of flooring, which sealed the asbestos and alleviated the need for environmental remediation during renovation. The Facilities Director also noted there was asbestos within the insulation of older pipe elbows of the plumbing and HVAC infrastructure.

The Facilities Director also noted there was asbestos within the insulation of older pipe elbows of the plumbing and HVAC infrastructure.

In accordance with Section P40 of the Codification of Governmental Accounting and Financial Reporting Standards, Pollution Remediation Obligations, we recommend that an analysis be performed of the potential liability related to remediation of asbestos, and consider its significance to the Hospital’s financial statements and related note disclosures.

As noted in the “Facility/Structure Assessment” section of this report, we noted the existence of certain conditions that would trigger an evaluation of potential impairment to the carrying value of the assets held by UMC. Such potential impairment could have a significant financial impact on the carrying value of the assets reported by the Hospital, along with related note disclosures.

Such potential impairment could have a significant financial impact on the carrying value of the assets reported by the Hospital, along with related note disclosures.

Chapter 5: Charge Structure Review

We reviewed the following data sources to determine how UMC's charge structure compared to the overall District market place: UMC's most recent Medicare cost report, the statewide cost to charge ratio's (CCRs) issued in the Medicare fiscal year 2012 inpatient prospective payment system (PPS) regulations, District of Columbia Hospital Cost Reports, and DC Medicaid claims for all hospitals in the District. Further, UMC patient specific charges by revenue code were obtained and the patient specific costs were determined to compute the CCRs.

The internal hospital data suggests that outpatient charges are high and inpatient charges are low compared to the District market.

The results of this analysis were inconsistent. The Medicare inpatient CCRs appear comparable to the statewide Medicare inpatient CCRs. The Medicaid inpatient data would suggest that UMC's CCR is higher than the statewide Medicaid inpatient average CCR. The internal hospital data suggests that outpatient charges are high and inpatient charges are low compared to the District market.

UMC's fiscal year ended December 31, 2010 Medicare cost report was reviewed to determine the average ratio of cost to charges. It was determined that Part B physician cost and charges were not properly excluded from allowable cost on Worksheets A-8-2 and Worksheet C. With the correction of this error, the Medicare cost report reflected an overall cost to charge ratio of 31.55%.

Tables 8A and 8B contained in the fiscal year 2012 Inpatient PPS regulations reflect a statewide cost to charge ratio for the District of 32.5% for operating cost, and 2.0% for capital cost. Therefore, the overall statewide cost to charge ratio is 34.5%. UMC's hospital specific cost to charge ratio for operating and capital costs are 33.4% and 1.3%, respectively. The total Medicare hospital specific cost to charge ratio for UMC is 34.7%.

UMC's cost to charge ratio for Medicaid inpatient services is 45.6% for inpatient and 20.5% for outpatient services. The overall average CCR for Medicaid inpatient services in the District is estimated to be 40.74% based on a review of claims data for all hospitals in the District.

An analysis of the fiscal year 2010 Medicare cost reports for select District hospitals is included as Exhibit C. This analysis reflects CCR's for each of the selected hospitals, calculates the median CCR and compares the median CCR to UMC. This analysis should only be used as a guideline because it does not take into consideration factors such as low utilization and productivity. Exhibit A identifies that the CCRs for medical/surgery, blood, physical therapy and supplies at UMC are high compared to the District market. This suggests that charges may be low. It is assumed that the high CCR for nursery and labor and delivery room is due to low utilization. The high CCR for

anesthesia is due to the fact that UMC did not remove the Part B anesthesiology physician costs from the Medicare cost report.

Exhibit A identifies that the CCRs for lab, respiratory therapy, EKG, clinic and emergency room are low compared to the District market. This indicates that charges in these departments may be high compared to the market.

Our recommendation for the Hospital is as follows:

- The medical/surgery, blood, physical therapy and medical supply rates at UMC should be reviewed in more depth to determine if a rate increase is warranted.

Chapter 6: Managed Care Contracts Review

We selected significant managed care contracts for review to determine if the managed care organizations are reimbursing UMC at comparable market rates, if multiyear contracts have appropriate annual inflators, and if appropriate reimbursement methodologies are incorporated. This review excluded Medicare and Medicaid managed care payors.

Hospital personnel provided a copy of an Insurance Matrix and a download of all managed care patients classified as “HMO” financial class in the patient accounting system, with dates of discharge/service from September 1, 2010 to August 31, 2011. The data from this file was used to identify the significant managed care contracts. Specifically, the data was separated by managed care company, paid versus non-paid claims, and split between inpatient and outpatient claims.

The top three managed care payors grouped as “HMO” in UMC’s financial system are Aetna US Healthcare, Kaiser and United Healthcare*74080. These three payors represented approximately 70% of the billed “HMO” claims for the twelve months reviewed, and approximately 74% of the paid “HMO” claims. Exhibit D delineates the charges and payments related to these top three managed care organizations and the total HMO population at UMC.

It appears that some Medicaid Managed Care payors (i.e., United Healthcare-MMA) are being incorrectly grouped as “HMO” instead of “Medicaid HMO” in the patient accounting system.

HMO claims are approximately 6% and 8% of gross inpatient and outpatient charges, respectively. It appears HMO utilization has been steadily increasing over prior periods.

The payment to charge ratio of paid claims identified in the data for patient claims with a primary insurance designation of HMO is approximately 39% and 51% for inpatient and outpatient claims, respectively. The overall payment to charge ratio of paid claims is 47%. It is important to note the payment to charge ratios mentioned herein are determined based on paid HMO claims.

For claims between six and twelve months old, 10.82% and 8.17% of inpatient and outpatient claims, respectively, remain unpaid. Overall 9.32% of inpatient and outpatient claims are unpaid for the HMO patient accounts aged between six and twelve months from the date of discharge/service.

Copies of major managed care contracts were requested from hospital personnel. A copy of the Kaiser contract was not provided by hospital

personnel, nor was a current copy of the United Healthcare contract. It appears that UMC may not have a contract with Kaiser, as the payment to charge ratio on paid claims exceeds 97%.

The effective date for the Aetna contract is July 1, 2009, with a five year term. Starting July 1, 2010 through June 30, 2014, the Hospital receives an annual 5% COLA on the fixed contract rates. This is an equitable COLA adjustment factor. Inpatient per diem rates appear to be slightly below market. Outpatient cardiac catheterization rates, observation services and CAT scan rates appear to be approximately 10% - 12% below average. Implants are not paid in addition to the per case ambulatory surgery rates. In addition, the primary or highest surgical procedure case is paid at 100% of the contracted rate. The secondary procedure is reimbursed at 50% of the contracted rate. Subsequent procedures are reimbursed at 25% of the contracted rates. It is often common in the market for all subsequent procedures (other than primary) to be reimbursed at 50% of the contracted rate. This is analogous to the Medicare methodology. If you consider these two variables Ambulatory Surgery rates may be 5% - 10% below the market (dependent on utilization).

The Aetna payment to charge ratio (PCR) is 24%. The rates in the contract, considering the COLA adjustment factor appear reasonable. The overall PCR suggests that Aetna may not be paying according to the terms of the contract. A sampling of Aetna claims was taken and the results were inconclusive. Overall, the Aetna contract appears reasonable.

The contract provided for United Healthcare is dated October 5, 2005, and was amended September 15, 2008. The contract states that in the event of a change of ownership, the agreement will be assigned only if the UMC requests that United approve the assignment of the agreement, and only if United approves the assignment of the agreement. No documentation related to the assignment of the agreement to new entity was provided.

The United Healthcare contract does not have a COLA adjustment build into the terms of the contract. The 2005 United Healthcare agreement has an initial term of four years and renews automatically in one year increments, until terminated. The United Healthcare payment to charge ratio is 30%.

Our recommendations for the Hospital are as follows:

- Determine whether assignment has been provided to the new entity by United Healthcare. UMC should consider hiring a professional managed care negotiator to review the terms of the 2005 Agreement and re-negotiate the terms, as necessary. The negotiator should review the terms of the other major managed

care contracts to determine if any action should be taken to terminate and renegotiate the terms of these contracts.

- Continue to be a non-contract provider with Kaiser.
- Establish pro-ration rules and test any existing pro-ration rules in the MEDITECH system for all of the managed care contracts.
- These pro-ration rules will determine the estimated patient specific claims payments based on the terms of the contracts. Subsequent to establishing such parameters, UMC should investigate any payments that are less than the anticipated payment amount.
- Conduct a comprehensive review to determine, retrospectively, if managed care payments have been paid according to the terms of the agreements. The sampling of these claims should focus on any claims that have a low payment to charge ratio compared to the average and large dollar claims.

Conduct a comprehensive review to determine, retrospectively, if managed care payments have been paid according to the terms of the agreements.

Chapter 7: Facility/Structure Assessment

Summary

It appears that the core infrastructure of the Hospital is in good working order…

It appears that the core infrastructure of the Hospital is in good working order, and costly facility and bio-medical equipment, such as boilers, radiology equipment, elevators, and HVAC, is monitored under a combination of regularly scheduled maintenance performed internally, preventative maintenance contracts with third-parties, and manufacturers warranties. However, we did indentify other notable matters that currently impact the Hospital financially and operationally. Such matters include:

- Patient care rooms which appear to be out-dated and in need of upgrades to aesthetics, equipment and technology. Approximately 30 patient care rooms have already been upgraded at a cost of approximately $21.2 million.
- Significant amounts of excess capacity.
- Renovation to SNF bathrooms, and expansion and renovation to common, dining and activity areas.
- Repair of new flooring in the Woman's Health Department.
- Significant renovation to the kitchen and cafeteria, including equipment replacement.
- Replacement of water treatment system and out-of-code electrical switchboard.
- Significant upgrades to the overall aesthetics, particularly "Main Street", which is the main thoroughfare of the Hospital connecting the main entrance to the ED.

We were informed by the Hospital's Executive Management that a long-term capital budget has been prepared, including an analysis of funding such capital improvements; however, we were unable to obtain this budget and analysis during the term of our project.

We were informed by the Hospital's Executive Management that a long-term capital budget has been prepared, including an analysis of funding such capital improvements; however, we were unable to obtain this budget and analysis during the term of our project. A budget we were able to obtain was for fiscal year 2011. This budget provided for approximately $4 million of capital expenditures, funded by operating cash flow.

We obtained UMC's capital improvement and replacement budget to gauge the cost associated with the plan, including if there are major repairs or replacement of major equipment that UMC will have to undertake, and the estimated costs associated with such repairs or replacements. We also toured the Hospital, including the mechanical buildings/rooms, with the Director of Bio-Medical Equipment, Facility and Maintenance Director, and the Executive Vice President of

Operations, and made record of our discussions and observations.

The details of our tour and assessment of the facility are as follows:

Renovation of Patient Rooms
We viewed room #850, which is a semi-private un-renovated room. The overall appearance was dated, with significant work needed to improve the aesthetics and modernize the equipment and technology contained in the room. According to the Executive Vice President of Operations, approximately 30 rooms have been renovated to-date at a cost of approximately $300,000. This work was performed prior to the District assuming the Hospital. According to the appraisal report for the Hospital performed at the time the District took ownership, management indicated that plans are underway to renovate several of the inpatient floors, with a total capital expenditure of $21.2 million. There are approximately 200 rooms for in patient care in the Hospital.

Excess Capacity
The Hospital appeared to have an abundance of unused space in patient care and administrative areas, including the following: 50% of the 8th floor, 25% of the 5th floor, 50% of the psychiatric wing, 50% of the intensive care unit (ICU), and 50% - 75% of the cafeteria area. The Hospital also has significant excess capacity available in the prison wing, skilled nursing facility, and the entire 3rd floor (women's health).

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The Hospital also has significant excess capacity available in the prison wing, skilled nursing facility, and the entire 3rd floor (women's health).

Only one side of the ICU, which consists of 8 beds with doors, is generally being staffed and utilized. The side used is more desirable for use as the doors provide better control of potential infectious disease. The unused side contains 8 beds without doors, which would require renovation of the HVAC infrastructure to add doors. In addition, the ICU appears to have abundant surgical resources, patient beds, and updated technology compared to the level of utilization.

From a financial reporting perspective, the entity does not have a formal process in place to evaluate impairment triggers or perform the necessary impairment analysis, which could have a material effect on the financial statements (see matters documented in the Acquisition, Depreciation and Disposal of Property and Equipment section of this report).

Skilled Nursing Facility
Immediate need to renovate the shower stalls in rooms, as the current shower structure has experienced water leaks and is subject to mold/rot over time.

Although many patients receive their meal trays in their rooms, the entire activities/dining room does not have the capacity to accommodate the existing residents for dining, if needed. The capacity issue would become more urgent if occupancy increases.

Overall appearance of the SNF is dated and void of any personalization, as compared to a modern sub-acute care facility.

No outdoor activity areas designated for or accessible by able residents.

Overall appearance of the SNF is dated and void of any personalization, as compared to a modern sub-acute care facility.

Immediate needs for service equipment, furniture, and renovations. For example, there are no sealed carts available for clean linen. Rather, plastic is draped over regular carts for sanitation. Also, vacant patient rooms are being used as supply closets.

3rd Floor (Women's Health)

There is an empty wing on the 3rd floor. This area appeared to have been used for patient care, but is currently closed-off and vacant, because of the existing excess capacity on other floors.

Significant repair work to the wood flooring is required as a result of water damage.

Significant repair work to the wood flooring is required as a result of water damage. The wood flooring is warped and uneven.

Birthing classes are offered to the public every Saturday. Attendance varies from 1 - 7 mothers, according to the Labor and Delivery Nursing Supervisor. Additionally, information about these classes provided on the UMC website detail the class schedule for 2008. There appears to be an opportunity to create a greater presence in the communities of Wards 7 and 8 through this program, as it appears to be currently under-utilized. This program could help to increase overall volume in the women's health departments.

The 3rd floor appears to have the nicest aesthetics, and substantial renovation of all rooms is nearly complete. There is also new patient equipment and technology throughout the women's health area. However, not taking into consideration the closed/empty wing, the 3rd floor appears to have significant excess capacity in light of the capital investment made on this floor. At the time of our tour, we observed that there were no patients in labor and delivery, nor any babies in the nursery, neonatal intensive care unit (NICU), or intermediate care rooms. There were also a minimal number of patients occupying the OB/GYN beds.

Kitchen/Cafeteria

Virtually all equipment and furnishings in the kitchen and cafeteria are in need of replacement. The Hospital has struggled to furnish a salad bar and cold sandwich station with its current equipment because of the inability to meet Department of Health guidelines. Therefore, the options have been placed on-hold until new equipment is acquired.

Few patients or families of patients were observed in the cafeteria during our time on-site.

Few patients or families of patients were observed in the cafeteria during our time on-site.

Only a small portion of the total dining room space is furnished with tables and chairs for use by cafeteria patrons, while the remainder of the space is completely empty. It also appears that there are private conference/meeting rooms attached to the dining area, which also appears to be unused.

The overall feel of the kitchen is cramped and chaotic, while the cafeteria area is dim and dated. The food quality is average, and healthy food options are minimal.

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Penthouse and Boiler Room

The penthouse is the mechanical room atop the Hospital. The penthouse and boiler room were well organized, free of clutter and all equipment appeared functional and accessible. The elevator control room appeared new. We did note leakage with a rusted through drain pan for the HVAC and exposed piping insulation. The Facilities Director indicated the leak will be fixed when the Hospital is able to shutdown the air conditioning without violating any regulations or codes, which is likely in the fall/winter.

We were informed by the Facilities Director of two significant projects needed at the Hospital, a water treatment system and replacement of an out-of-code electrical switchboard. The Facilities Director also indicated that the remaining useful life is 10 – 20 years for most equipment, and 40 years for the boilers. The Facilities Director also indicated the HVAC has approximately 20 years of useful life remaining.

Main Level/Lobbies

The lobby inside the main entrance of the Hospital, adjacent to the security desk, is furnished with old and worn furniture.

The lobby inside the main entrance of the Hospital, adjacent to the security desk, is furnished with old and worn furniture. Also, it appears to be much less utilized than the out-patient waiting area located further down the corridor from the main entrance. The out-patient waiting area is relatively small and typically full of patients and their families awaiting registration. These individuals intermix with personnel and foot traffic waiting for elevators. We were informed by the Executive Vice President of Operations that the Hospital intends to renovate the entire “Main Street”, including paint, trim, décor, signage, furniture, fixtures, flooring, foot traffic flow, and more. Main Street is the thoroughfare created by the Hospital linking the main entrance to the emergency department, which is of notable distance.

Other Notes

On the 8th floor, we noted a room for soiled linens being used as the staging area for food service.

A variety of mobile diagnostic equipment is in the process of being replaced. According to the Director of Bio-Medical Equipment, much of

the “big ticket” bio-medical equipment has been replaced. New equipment on the horizon includes bedside ultra-sound machine and a minimally invasive Vigileo monitor for the ICU.

Prison Wing – The District only reimburses the Hospital for ‘occupied’ prison beds. However, the Hospital incurs a minimum level of cost regardless of occupancy, as three corrections officers and a clerk must be on-site in the prison wing 24/7, regardless of census.

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Bio-medical Engineering and Building Services departments maintain listings of equipment for purposes of tracking location, transfers between clinical locations, service and maintenance requirements, warranties, and work orders. According to the Director of Bio-Medical Equipment and Facilities Director, all significant equipment is maintained according to manufacturer and regulatory specifications. Much of the costly bio-medical equipment is maintained under preventative maintenance agreements, while most mechanical equipment is maintained internally by the Building Services department.

Chapter 8: Skilled Nursing Facility (SNF) Assessment

Based on our observations of interactions with other departments within the Hospital, it appeared the Hospital is struggling with integrating the SNF because of unique requirements and regulations.

Summary

The physical environment is institutional in appearance; we observed no obvious discerning difference compared to other units within the confines of the Hospital at large. Based on our observations of interactions with other departments within the Hospital, it appeared the Hospital is struggling with integrating the SNF because of unique requirements and regulations. The requirements and regulations for the SNF may not be consistent with the Hospital requirements.

For example, we witnessed interaction of a kitchen staff member instructing the nurse that "if they do not get change requests on food trays by 9 am it will not be switched in time." The kitchen staff member informed the nurse that this floor is like every other floor in the Hospital, despite the nurse's attempts to explain that as a SNF they must comply with reasonable food choices. This illustrates one unique requirement and an opportunity to educate hospital departments serving the nursing home.

Unique Challenges Operating a SNF

- The rooms and hallways appear clean; no biologic odors noted during brief tour.
- Varied ages of the residents.
    - Residents of varied ages tend to have a range of interests; facilities are expected to meet the needs of the residents with age appropriate activities and create opportunities for peer interaction in an effort to foster enhanced quality of life. We did not observe directed activities for the residents.
- Varied programs based on resident admission status.
    - Residents appeared to be mixed together without regard to stay or condition; for example, there did not appear to be separation of short-term residents, with an anticipated short-term discharge plan, from the general long-term placement residents, including the dementia population.
- There were instances of staff name tags not visible, tags were turned around so the staff member's name and title was not identifiable.
    - It is a requirement that residents know the identity and title of the individual providing care.

- In our opinion, the environment lacks a comfortable, home like setting. There appeared to be a lack of sensitivity to this requirement, evidenced by frequent over-head paging and relatively loud conversations amongst the staff.

We assessed certain aspects of UMC's nursing center (UMNC) operations in an effort to determine if significant regulatory compliance risks exist, as well as to perform a high level assessment of the SNF's sustainability as a component of the Hospital.

The facility lacks a 'home' feel like that found in competing facilities. It appears the SNF serves a very specific resident type (i.e., UMNC is the only option), rather than being a viable option for all prospects evaluating home choices in the District.

We also reviewed a sample of ten clinical records to assess whether bills generated for services rendered were supported by the presence of clinical documentation. We spent two days reviewing records, as well as interacting with administrative, clinical and business office team members, to gain an understanding of current processes, policies and procedures related to billing, clinical documentation and other related documents maintained to support the basis of a Resident's care. While the primary responsibility of the clinical team is to assess, implement and monitor care for each resident, in order to maintain function and quality of life at the highest practicable level, the documentation related to that process and the resulting bills generated for the services rendered are the tangible evidence that undergo regulatory review and audit.

Whether the audit is a pre-payment or a post-payment audit, clinical records are reviewed and conclusions reached with regard to the care provided (i.e., was the care reasonable and necessary), as well as accurately captured on the bills submitted. Should a determination be made the record does not sufficiently support the resource utilization group (RUG) level captured under the case mix guidelines for the District, or fails to support the RUG-IV level captured under the Medicare-A requirements, at a minimum a repayment request will occur. Consequently, it is reasonable to state that the condition of the SNF's records have a direct impact on the financial results of the Hospital.

Due to differences in regulations, clinical care models, service billing, and Resident and family wants and expectations, the keys to operating a successful SNF are unique, and can vary significantly from the traditional hospital environment.

Due to differences in regulations, clinical care models, service billing, and Resident and family wants and expectations, the keys to operating a successful SNF are unique, and can vary significantly from the traditional hospital environment. Through our assessment, we identified certain quality of life and regulatory and financial matters for UMC to consider. Unlike a short stay hospital environment, many residents of a SNF are there for an extended period of time. Therefore, regulations and resident wants and expectations require, at a minimum, a satisfactory quality of life. In addition, the regulatory and financial environment can be complex and oversight from regulatory agencies can be strict.

As a result of the Medicaid rate rebasing currently being performed, it is expected that Medicaid reimbursement rates for SNF services will be

significantly reduced. Also, while UMNC is currently exempt from paying the District provider tax of $3,000 per licensed bed, should UMNC become a non-government owned entity, this annual tax would be due. Both factors will put considerable strain on the financial viability of the SNF operation.

In light of these factors, we believe the following matters are critical to the overall sustainability of the SNF operations.

Quality of Life

Hospital departments serving the SNF, as well as certain SNF staff, appear to lack the understanding of the differences between the operating and regulatory environment of the SNF versus the rest of the Hospital, which may be the result of lacking education.

The facility lacks a 'home' feel like that found in competing facilities. It appears the SNF serves a very specific resident type (i.e., UMNC is the only option), rather than being a viable option for all prospects evaluating home choices in the District.

Common/activity areas and dining rooms are inadequate to accommodate residents.

Availability of age and condition appropriate activities and peer interaction is limited.

Hospital departments serving the SNF, as well as certain SNF staff, appear to lack the understanding of the differences between the operating and regulatory environment of the SNF versus the rest of the Hospital, which may be the result of lacking education.

Regulatory and Financial

- Improvement is needed in the overall completeness of the documentation contained in resident files to support billings, including therapy activity, activities of daily living (ADL) assessments, and comprehensive care plans (CCPs).
- A response plan should be developed for implantation of new therapy regulations which were effective October 1, 2011.
- Admissions and assessments procedures should be refined to minimize Medicaid Pending residents.
- A specific strategy should be developed for the transition to MDS 3.0 and RUG IV effective October 1, 2011, which significantly impacts the billing process.
- As a result of the Medicare billing back-log, UMNC should consider engaging a consultant that will ensure the backlog is properly processed and supported and reimbursement is maximized, and will coordinate/communicate with CMS throughout the process.
- Until recent, the proper controls over resident funds had not been implemented. At the time of our assessment, UMNC was in the process of ensuring the proper safeguards.

The results of such surveys and/or regulatory audits of documentation supporting billed services could have a significant financial impact on the SNF operations.

We noted our observations are consistent with some of the observations and findings contained in the SNF's most recent survey performed by CMS. The results of such surveys and/or regulatory audits of documentation supporting billed services could have a significant financial impact on the SNF operations. For example, a SNF may be placed on Additional Documentation Request (ADR) status, which essentially halts UMNC's ability to bill for services until all findings have been addressed with the oversight agency.

Rehabilitation Matters

Therapy Model

We confirmed, through the review of treatment plans for the sample of residents selected and discussion with the Director of Rehabilitation, that the restorative therapy treatment model at the facility is five days per week, with one additional day, as needed. Effective October 1, 2011, should a resident fail to receive services for three days, an end of therapy (EOT) assessment is required to be completed. If the resident resumes therapy under the same intensity within five days of completing the EOT, an end of therapy resumption (EOT-R) assessment is required to be completed. These assessments are in addition to the pre-existing Medicare Prospective Payment System (PPS) and Omnibus Budget Reconciliation Act (OBRA) scheduled assessments. There is an increased likelihood of the need to complete additional assessments for facilities that offer five day, versus six or seven days of therapy per week.

We encourage the facility to consider expanding the current treatment model and increase therapy availability to six days per week.

To illustrate, a resident scheduled Monday through Friday attends each of the sessions. The resident does not attend a session on the weekend and elects not to attend the scheduled session on Monday. As a result this resident was not treated for three consecutive days; therefore, an EOT must be completed for this resident. Should the resident agree to resume on Tuesday, an EOT-R will also be required. This demonstrates that a five days per week therapy model may place the facility at increased risk of incurring costs associated with completion of additional assessments. We encourage the facility to consider expanding the current treatment model and increase therapy availability to six days per week.

Technical Matters

Rehabilitation Certifications

Certifications for Medicare-A stays completed by a physician covers the provision of services ordered by that physician and/or recognized authority. Therefore, completion of individual therapy certifications for Medicare-A is not required. However, the presence of incomplete certification forms does place the facility at risk for being cited for non-compliance with its own policy and procedures. An example of this was observed for chart A000093. This record had a plan of treatment

certification form dated August 3 through 31, 2011. The use of the certification form was unnecessary because this was a Medicare-A stay. We recommend discontinuing individual certifications for residents receiving skilled rehabilitation under Medicare-A benefit.

Documentation

We interviewed the Director of Rehabilitation regarding documentation to support individual, concurrent and group therapy. The clinical staff utilizes the Casamba electronic records for 'per encounter' documentation, which includes the date and delivery time of each treatment provided, as well as the clinicians' signature and date. While the format presumes individual treatments with documentation by exception for concurrent, we were unable to locate an area to document group therapy, which is the third recognized treatment modality. We were informed that the only treatments rendered by the SNF are individual sessions. Group therapy is a recognized modality and, as such, should be planned and supported as clinically relevant.

Currently, the department does not maintain a documented therapy schedule for each resident on therapy programs. The absence of detailed records to support the treatment modality provided lessens defensibility of the record. We recommend the department schedule and maintain records of the treatment schedules for each resident on therapy programs, as well as the start and end time of each session. While not mandated, the presence of objective data to support the provision of individual sessions along with the ability to match against the time the therapist was on-site to treat their caseload, helps to sustain defensibility of the treatment record and ultimately the payments received. Overall best practice dictates a form of tracking and verifying both the treatment session schedule and the time spent with the clinicians.

Overall best practice dictates a form of tracking and verifying both the treatment session schedule and the time spent with the clinicians.

The rehabilitation department's current screening tool, the "Physical Therapy Functional Needs", is an outdated template as evidenced by references to Minimum Data Set (MDS) 2.0 sections and resident assessment protocols (RAPs). Additionally, we recommend removing documentation in the screening tool related to skin integrity/conditions, unless this discipline ultimately will be responsible to manage the care of the condition. While therapy is often called upon to assist with positioning devices to alleviate pressure and promote comfort, we did not see evidence that they are providing specific treatments to wounds. Therefore, having documentation related to the status of STAGE III–IV ulcers should be eliminated. We did not access the SNF's policy associated with completion of this section of the form. If continued documentation by the therapist is deemed necessary as it relates to the status of wounds, we recommend reference be made to specific treatment interventions, such as the need for pressure reduction devices like wheelchair positioning cushions, etc.

Additionally, it was noted that the Rehabilitation Department does not keep or monitor staff productivity statistics.

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Activities of Daily Living (ADL)

The Nursing Department utilizes specific forms for documentation of a resident's ADL. The forms are inclusive to capture required aspects for MDS completion, specifically captured tasks, the level of resident participation, and the staff assistance required. For the sample we reviewed, the Certified Nursing Assistant's (CNA) completed the forms routinely; no blanks were identified.

We did note instances where residents with an ADL code 4/4 were documented as 3/3 back-to-back. This is the only time the documentation at this level occurs. All other times the documentation is 4/4. When such instances occur, it may be beneficial to review to determine if the activity/task occurred at a 3/3 or a 4/4, and if there is a potential for re-education for staff members. In the couple instances viewed, the documentation difference occurred in the look back window only.

There were instances where the ADL coded on the MDS was different from the ADL that would have been coded after review of the resident ADL Forms. It was also noted that in the narrative documented by nurses, terms like "assisted with ADL's" and "ADL's provided" even when a resident was documented as self-care on the ADL sheet completed by the CNA. In other instances, the ADL coded on the MDS was different (coded as higher) from the ADL form documentation without an accompanying documentation explaining the reason.

As staff and memory change, the medical record would be used solely for the determination and penalties could ensue.

In one instance, a seven (7) should have been used as the activity. The MDS was coded with an actual resident participation and staff assistance level instead. In all other instances, the increase documented on the MDS for the ADL code does not appear to have affected the RUG score assigned. However, we advise caution with this practice. Whenever differences appear between the medical record and MDS coding, a clarification note should be documented and retained on file. As staff and memory change, the medical record would be used solely for the determination and penalties could ensue.

It was suggested to the MDS nurse on-site to consider documenting and maintaining, in a secure location, the reason for the change when MDS coding is not reflected in the medical record. Consideration should be given to establishing of a policy and procedure to be followed.

There were a few resident ADL documentation sheets that did not indicate the month. This was brought to the attention of the unit ward clerk. There were a few sample resident ADL documentation forms that could not be located. In those instances, the sample was replaced with an alternate resident, when possible. The forms are to be kept in

the medical record for a period of three (3) months. There appeared to be deviation from this policy.

MDS Matters

MDS Transitional Readiness

We were made aware the clinical team was recently in-serviced by an outside consultant on the pending changes effective October 1, 2011. Attendees included Administrator, Director of Nursing (DON), Nurse Managers, Director of Activities, and representation of the rehabilitation staff. During the course of our review, several clinicians, including the MDS Coordinators, were seeking additional support and education on the significant MDS changes effective October 1, 2011.

We were unable to identify a specific strategy or procedure to address the transition taking place effective October 1, 2011 when MDS 3.0 and RUG IV changes take effect.

We were unable to identify a specific strategy or procedure to address the transition taking place effective October 1, 2011 when MDS 3.0 and RUG IV changes take effect. While the two MDS Coordinators demonstrate competence in their field, the remaining team members, including the preparedness required by the business office to monitor and track the change in payments, remain unclear. While on-site, we recommended completing assessments by September 30, 2011, as the assessment grace days previously available for use (19, 34, 64 and 94 days) are discontinued and no longer permissible effective October 1, 2011.

Resident Comprehensive Care Plan (CCP)

A resident's care plan is generated electronically through the Point Click Care system, and is based on the results of the MDS assessment process. This system provides a library of care plan templates, as well as free form availability, which when used correctly will foster individualized resident CCPs, as CMS mandates1 and the Department of Health requires.

On interview, it was represented that each discipline involved with resident care utilize the CCP document as the stand alone document for their disciplines CCP interventions; no separate care plans are generated. Review of the audit sample care plans identified the following patterns:

- CCP goals, interventions and expected outcomes are not always oriented to a measureable goal.
- CCP interventions may not support the goal statement and are not fully inclusive of all interventions.
- CCP interventions are not integrated amongst the disciplines in cases where more than one discipline may be responsible, or contribute to, the expected outcome for a specific goal.

[1] Long Term Care Survey Regulation Survey F 279; F280; F 309

- CCP individual customization is not evident; it appears the standard template intervention commonly chosen.
- The absence of social work interventions related to psychosocial and discharge planning was noted.
- There are residents receiving elopement checks every hour (visual checks) for long periods of time (not just for baseline assessment purposes) that do not have a CCP for unsafe wandering or elopement risk in the medical record.
- CCPs do not appear to be routinely revised in the interim period between standard MDS assessments.
- An opportunity may exist to review SNF policy, procedure and processes associated with the CCP process.
- An opportunity may exist for re-education of the Interdisciplinary Team (IDT) members associated with the requirements of resident CCPs.
- An opportunity exists to incorporate a formal performance improvement initiative related to resident CCPs into the Facility Quality Assurance/Improvement initiatives.
- Formal Nursing Restorative CCPs were not evident.
- There is a group of pre-printed paper CCPs that are not dated or specific for the resident, which were present in some resident medical records, in addition to the Point Click CCPs. It was reported that the pre-printed paper CCPs are the “old” system and are not to be in use.

Status of Billing

Medicare Number Application

The Administrator presented the last page of a communication from the Centers for Medicare & Medicaid Services (CMS) (which was undated) requesting additional information from the facility as part of the application process for provision of the Medicare Provider Number (MPN). As per the Administrator, communications from CMS are addressed to him, but the business office has been designated to respond and provide the additional information requests. We requested a status update related to the additional information requested in the letter shown; he agreed to follow up with the business office and

Of importance is the lack of readiness for utilization of the MPN once released. As of the time we were on-site, selection of software for transmission of their pending Medicare Assessments and associated billing to CMS had not been completed…there were no plans to run a "test submission" to address potential errors.

provide an update. Additionally, at the time of this review, the Administrator had not communicated with CMS representatives to determine whether additional information requests are pending or may result once the current data request is reviewed by CMS. We learned that the Administrator is not an employee of the hospital system and, as a result, is not brought into detailed interactions such as completion of remittance requirements for the MPN. While on-site, a representative from the business office shared that the previous day, Executive Management was informed by phone that their MPN was activated; although a release date for the certificate was not mentioned.

Of importance is the lack of readiness for utilization of the MPN once released. As of the time we were on-site, selection of software for transmission of their pending Medicare Assessments and associated billing to CMS had not been completed, which have been accruing since October 2010 (note: CMS does offer free software). Also, there were no plans to run a "test submission" to address potential errors.

Our recommendations for the Hospital are as follows:

- Utilize outside support with the initial transmissions back to October 1, 2010.
- Communicate with CMS to determine best strategies for submission of the significant back-log of billings that will be submitted.
- Recommend developing a relationship with the CMS representatives to enhance both timing and communications related to finalizing provision of the facility's MPN.
- The Medicare-A billings be reviewed by the MDS nurse to ensure support for the ADL is in place, where ADL changes may have been made by the MDS nurse and no longer agree to the medical record documentation.
- Perform an analysis of the billing practices for ancillary hospital services (e.g., CT scan, MRI, etc.) provided to residents of the SNF. In most instances, the appropriate process is for the hospital to bill the SNF, and for the SNF to then bill the applicable third-party payor.

Medicare-A and Medicare-B billing appropriateness could not be validated as the SNF has not performed the billing.

Medicare-A and Medicare-B billing appropriateness could not be validated as the SNF has not performed the billing.

Medicaid Billing

We are unable to provide an assertion related to the Medicaid bills associated with the resident sample selected for the following reasons:

Residents identified as Medicaid Pending were not and could not be billed:

- According to the business office representative assigned to oversee billing related to services rendered by the facility as of September 27, 2011, two of the applications were approved, while the other 57 were in various stages of approval.
- The pending status is the result of residents being admitted with community coverage. As a result, their beneficiary status requires modification which requires remittance of information to the Department of Social Services.
- It is our understanding that applications have been remitted and a monitoring system has been put in place for current and future applications.

Other Financial Matters

The business office representative had been recently hired (six weeks prior) to facilitate the billing processes for the SNF, and has undertaken an investigative action plan process to facilitate the billing process. The representative advised that the pick-up date for payment is 180 days prior to the completed and accepted application, with a process for appeal of payment for services rendered prior to such time period.

From October 2010 through June 2011, resident funds were comingled with operating funds of the SNF. These resident funds are primarily direct deposits of a Resident's Social Security benefit. SNF personnel are currently sorting through all deposits from October 2010 through the current date to determine that all resident funds can be adequately segregated and assigned to the rightful resident.

From October 2010 through June 2011, there were no policies or procedures in place to verify that Medicaid amounts deposited via electronic funds transfer (EFT) were posted to relieve the appropriate resident account receivable, and there was no comparison of remittance advice to amounts posted to the resident accounts in Point Click Care (PCC). Since the hiring of a temporary business office manager and temporary biller, management has started the process of matching Medicaid deposits to related remittance advice, and ensuring the appropriate amounts were posted to the correct resident account in PCC. This significantly limits the reliability and usefulness of the resident account receivable aging, which is a primary financial report used to monitor and pursue outstanding resident receivables.

Medical Record Documentation

Our review yielded situations where, based on available documentation, the level and/or reasonableness of care could be questioned in an audit by oversight agencies.

We reviewed a sample of ten clinical records to assess whether the bills generated for services rendered were supported by the presence of clinical documentation. For purposes of brevity, not all identified issue examples were noted below; rather, examples of trended items or items of potential risk were noted. See Exhibit E for list of Resident files reviewed.

Our review yielded situations where, based on available documentation, the level and/or reasonableness of care could be questioned in an audit by oversight agencies. In other instances, conflicts existed amongst the documentation supporting a Resident's acuity, and CCPs were missing and/or incomplete.

Resident Identifier A000105

Questionable medical necessity or need for skilled intervention: The SNF placed a long-term care (LTC) resident transferred to the facility as a LTC resident on Gait Training (occupational therapist (OT) documented patient was wheelchair bound). There was also an appearance of overlap between OT and physical therapy (PT). Schedule was 3 times/week for OT and 3 times/week for PT. Speech therapy (ST) was scheduled for 5 times/week for documented aphasia, while the MDS Coordinator noted B0600: Speech Clarity "Clear Speech".

Interventions from OT and PT appear excessive for current status, given permanent placement in LTC and previously placement at a surrounding SNF. While subtle gains appear to be made, the procedures performed upon admission of the transferred resident, as described, does not support the need for skilled rehabilitation services in lieu of Restorative Nursing. Typically, upon admission of the transferred resident, or soon after, an initial plan of treatment would be created to establish an appropriate maintenance program, with the goal of developing parameters for restorative nursing to follow, thus, ultimately maintaining the resident's highest quality of life and participation. This is more likely to be deemed reasonable than the provision of Very High Services since admission.

Overall, the duration of services rendered by OT and PT appears questionable considering prior level of function…

Overall, the duration of services rendered by OT and PT appears questionable considering prior level of function (PLOF) (i.e., wheelchair bound, history of traumatic brain injury, transferred to this facility from another LTC facility, and established need for extensive assistance). Additionally, the primary diagnosis of the resident was hyper-tension, recommend when primary diagnosis is not directly require Restorative Rehabilitation interventions, it is advisable to provide a secondary rehabilitation related diagnosis.

Resident Identifier S000077

Level of care provided appears excessive for documented clinical status.

The patient was admitted for resistive arterial blood gas (ABG) pneumonia, then isolated and placed on therapy.

Indicated interventions noted were initial baseline for balance, strength and ADLs, followed by transition to Restorative Nursing and maintain status until isolation lift was indicated. Level of care provided appears excessive for documented clinical status.

Resident Identifier S0000038
Resident file was missing the current care plan. Most recent in record was April 20, 2011. Upon request the Assistant Director of Nursing provided a care plan dated July 2011.

Other file documentation includes:

Pharmacy Sheets: February 11, 2011

- "PT Evaluation Only."
- Screen PT and OT.
- "OT Evaluation and Treatment as Indicated."
- Pharmacy Sheet: February 14, 2011.
- "PT Evaluation Only."

A late entry ST order for evaluation and treatment; 3 times/week to address cognitive linguistics, problem solving, and patient/caregiver educations.

PT functional needs; have skin integrity (MDS M1, 2, 3, 4, 5, 6; RAP 16) - skin is free of Stage III or Stage IV Wounds.

Resident Identifier A000101
The rehabilitation PT and OT care plans and resultant delivered therapies had common goals for strength, which is duplicative and considered not appropriate. Safety was not listed as a goal, which should have been as resident was toe-touch weight bearing status on one leg.

Diagnosis documentation – the diagnosis noted within the MDS did not match the current treatable diagnosis in the medical record, and did not appear to be revised when medical conditions are identified and treated. The diagnosis within the MDS matched the admission diagnosis and was not revised.

Resident Identifier A000035
Resident is a Medicaid Pending resident – no Medicare-A or Medicare-B noted. Resident was diagnosed and, in part, treated for a chronic liver disease (cirrhosis of liver related to Hepatitis C), portal hypertension and esophageal varicies during the course of admission to the SNF. The hepatic condition and associated conditions were not listed on the chart problem list or the MDS.

The Resident is listed as, and known to be, self care on the ADL documentation forms. However, the MDS is coded differently; giving a credit of assist. The nurses notes document ADL provided, even when the CNA documentation reflects self care. The Resident's coding initially and currently (PA1 now) would not have changed.

As an additional observation, this Resident was admitted with a Stage II Pressure Ulcer from the hospital. Section M of the MDS indicates no pressure ulcer and no risk. This Resident had an open ear area that was not noted in May 2011, however, the skin check forms from May through July 2011 all document that the skin was intact. The MDS does not note the open ear area, and the Resident does not have a comprehensive care plan (CCP) for this open ear area.

The initial pre-admission screening and resident review (PASRR) was not in the medical record.

The initial pre-admission screening and resident review (PASRR) was not in the medical record.

Resident Identifier A000061
Resident is Medicare-A and Medicare-B, and also Medicaid Pending status. The PASRR was appropriately completed and in the record. The Resident was admitted with dementia with behavior disturbances. The Resident was resource utilization group (RUG) level BBI, with no behavior instances captured/documented on the behavior forms in the record. The MDS reflects significant differences from the CNS documentation on the ADL forms. The CNA ADL documentation forms reflect self care with respect to toilet, transfer, bed mobility, locomotion on the unit and eating. The MDS coding reflects supervision required for bed mobility, locomotion on unit and eating. The MDS coding reflects a three 3/2 for toilet use. The CNA ADL form reflects a 4/2 for dressing and a 4/3 for personal hygiene. However, the MDS codes a 3/2 and a 3/2, respectively, for the same tasks.

The CNA forms reflect the resident with more independence the first 15 days of the month, and an increase in the need for assistance and an increased dependency the later part of the month (the look back period).

Resident Identifier A000101
Resident has Medicare-A and Medicare-B, and Medicaid. Resident was admitted following a motor vehicle accident (MVA), in which multiple injuries were experienced, including a surgically repaired fracture of the right leg. The resident was admitted for short-term rehabilitation. The resident also has a history of anxiety.

The files provided contained no CCP for discharge planning. It was noted the resident resides in a homeless shelter. The CCP noted to us as being the discharge plan CCP was not appropriate or sufficient for a discharge plan. It was more consistent with a care plan to assist the resident with adjustment to new surroundings for rehabilitation. The care plan language states "To assist her to feel wanted during her

facility admission". There is no evidence of activities related to preparing the Resident for discharge. There was also no social work involvement evidenced in the file. When reviewed with the Unit Nurse, the nurse reported that they would create and implement a discharge plan, including all preparations required to meet the Residents needs, upon discharge.

The resident was admitted with multiple wounds (non pressure ulcer). There was not a CCP for the existing wounds. Additionally, the resident's skin check forms were noted to be "skin intact", while the resident's wounds were noted elsewhere in the record as still healing with treatments.

The resident required PT and OT for rehabilitation. There is evidence in the notes that the resident was having difficulty with anxiety, "motivation" and complaining of "pain". It was documented that the Resident refused, or cut short, some therapy sessions as a result of "pain". The CCP does not integrate this resident's need for anxiety management, motivation strategies or pain management related to therapy to achieve the expected outcome associated with the resident goal of restoring prior function. The therapist did note the resident was "depressed" and should have a psychiatric consultation, which was obtained. The staff did reassess the resident's pain; however, this reassessment did not take place during therapy when the resident was known to have pain.

These matters create the potential for quality of care findings, which could adversely affect the SNFs ability to obtain reimbursement from third-party payors for services performed. In addition, therapy time is lost, creating the potential for lost billings and a decrease in RUG reimbursement rate.

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Chapter 9: Medicare, Medicaid and Disproportionate Share

Summary

Key findings from our assessments of certain aspects of the Medicare and DC Medicaid programs and the related impact on UMC include the following:

- Based on the District's State Plan Amendment (SPA), we estimated that the increase in annual DC Medicaid rates due to the implementation of APDRG grouper version 26 and the new base rate will be approximately $2.6 million. UMC's APDRG base rate and the other District hospitals' base rates appear to be calculated in accordance with the SPA, with certain exceptions.
- We verified a Medicare termination cost report was not filed for period immediately preceding the change of ownership on July 9, 2010, which is a requirement. Further, it was verified that no request has been made to change the cost reporting year end from December 31 to September 30, which is the accounting year end for the Not-for-Profit Hospital Corporation.
- We noted UMC's Medicare cost report for the year ended December 31, 2010 reflects no Medicare reimbursable bad debt for deductibles and coinsurance amounts. This represents an opportunity for UMC to obtain additional Medicare reimbursement.
- We also noted the patient specific DSH listing to support the Medicaid fraction in the Medicare DSH computation was not provided because it was never prepared. As a result, an alternate method was used to calculate the Medicaid fraction. The Hospital received approximately $3.3 million in Medicare operating DSH payments related to the fiscal year ended December 31, 2010. We determined UMC has not properly reported the Medicaid fraction in the DSH calculation. Further work will need to be performed to determine the increase or decrease in Medicare DSH payments.
- For fiscal year 2011, UMC received $14.9 million in Medicaid DSH payments. We performed procedures to determine if any portion of the payments will be retrospectively disallowed. We determined the data included in the DSH data collection tool, which was developed by DHCF, does not appear to be accurately reported. The major flaw in the data is the calculation of the ratio of cost to charges. All other factors remaining the same, the recalculation of the data using a proper

cost to charge ratio, based on the Medicare cost report, would reduce the DSH payment from $14.9 to an estimated $13.2 million, using the 2010 tool for the fourth quarter only, and an estimated $11.2 million, if the revised 2010 tool were used for the entire fiscal year 2011.

As noted in many of our recommendations, we believe it is imperative for UMC to engage qualified professionals, either through employment or consulting arrangement, to oversee the preparation of its cost reporting and DSH data collection to ensure all requirements and regulations have been appropriately addressed.

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State Plan Amendment

We performed a review of the District's State Plan Amendment (SPA), which changed the prospective payment methodology for DC Medicaid recipients. Our review was performed for the purpose of estimating the increase/decrease in DC Medicaid rates paid to UMC.

The DHCF updated the payment method for inpatient hospital services effective April 1, 2010. We reviewed the Notice of Final Rulemaking, dated May 11, 2011, relating to the adoption of the new inpatient hospital payment method. The previous method was using All Patient Diagnosis Related Group (APDRG) grouper version 12. This grouper was over fifteen years old. The new payment method updated the grouper to version 26.

The base payment rates were updated and based on hospital-specific costs obtained from the fiscal year 2006 submitted cost report. The hospitals were separated into three (3) peer groups; children's hospitals, community hospitals, and major teaching hospitals. UMC was included with Providence Hospital and Sibley Hospital in the community hospital peer group. UMC's final base payment rate is equal to the community hospital peer group average cost per discharge adjusted for inflation and other factors.

The hospital-specific cost per discharge was developed to take into consideration indirect medical education costs, capital cost, and variations in case mix and were adjusted downward to create an outlier reserve.

The detailed calculations of the new APDRG base rates were performed by Affiliated Computer Services, Inc. (ACS) under the direction of DHCF. We reviewed UMC's detailed calculations for accuracy.

The new payment method was effect April 1, 2010; however, grouper version 26 and the new base rates were not installed until October 1, 2010. Therefore, claims from April 1, 2010 through September 30, 2010 were paid at the old base rate which used grouper version 12. The claims from April 1, 2010 through September 30, 2010 were

reprocessed and DHCF personnel provided a detailed spreadsheet of the results of the retroactive claims processing.

A download of paid claims from July 1, 2010 through June 30, 2011 was provided to us by UMC personnel. These claims were reviewed to determine the average payment rates before and after the rate change.

The results of our review yielded the following:

- The UMC APDRG base rate effective July 1, 2003 was $6,279. The UMC APDRG base rate effective April 1, 2010 is $10,950.
- The base rate is calculated at an APDRG relative weight of one (1.0) and does not consider case mix, transfers and outliers. Therefore, the base rate is not reflective of the average payment rate. Based on the reprocessed claims file from DHCF (using only non-exception claims), UMC's average APDRG payment, including transfers and outliers, immediately prior to the update in the payment method was $9,674. Based on UMC's paid claims file, using dates of discharge from October 1, 2010 through June 30, 2011, UMC's average APDRG payment, including transfers and outliers, subsequent to the update was $11,397. Therefore, the average payment rate has increased an estimated $1,723. Using the eight months ended August 31, 2011 "Trended Utilization Statistical" report as an average, estimated annual DC Medicaid discharges are approximately 1,525. Therefore, it is estimated that the increase in annual DC Medicaid rates due to the implementation of APDRG grouper version 26 and the new base rate will be approximately $2.6 million.
- UMC's APDRG base rate and the other District hospitals' base rates appear to be calculated in accordance with the SPA, with certain exceptions. DHCF directed ACS to adjust the final base rates so that each hospital's payment to cost ratio was between 95% and 100%.

Medicare Cost Report – Proper Filing

We obtained from UMC a copy of the filed Medicare cost report for the fiscal year ended December 31, 2010. We reviewed the cost report to determine whether UMC has properly filed required cost reports.

When a hospital undergoes a change of ownership ("CHOW") of this type, a termination cost report is required to be filed.

On July 9, 2010, the District foreclosed on UMC for non-payment of loans owed to the District and acquired UMC. Simultaneously, the District contributed the foreclosed assets and assumed liabilities to the Not-for-Profit Hospital Corporation. When a hospital undergoes a change of ownership ("CHOW") of this type, a termination cost report is required to be filed. A copy of the Medicare cost report for the fiscal year ended December 31, 2010 was obtained from the Hospital and it was verified with Highmark Medicare Services (Highmark), the Fiscal

Intermediary/MAC (FI/MAC), that no termination cost report was filed. Further, it was verified with Highmark that no request has been made to change the cost reporting year end from December 31 to September 30, the accounting year end for the Not-for-Profit Hospital Corporation. We performed a cursory review of the Medicare cost report for the fiscal year ended December 31, 2010.

Per Medicare regulations, a hospital must adhere to the cost reporting period initially selected unless a change has been authorized in writing by its FI/MAC.

As mentioned above, it was verified with the FI/MAC that no termination cost report was filed for the January 1, 2010 through July 8, 2010 period. Further, the FI/MAC verified that no request has been filed to change the cost reporting year end from December 31 to September 30. Per Medicare regulations, a hospital must adhere to the cost reporting period initially selected unless a change has been authorized in writing by its FI/MAC. For the change to be effective, the hospital's written request must be received by the FI/MAC 120 days or more prior to the close of the reporting period which the change proposes to establish. Such a change may be made only after the FI/MAC has established good cause. The specific circumstances related to the change must be explained and documented by the hospital.

The cost report reviewed reflects no Medicare reimbursable bad debt for deductibles and coinsurance amounts. According to the independent consultant who prepares the cost report, the patient specific bad debt logs were not supplied by UMC for the Medicare/Medicaid cross over bad debt, or the agency bad debt. Medicare pays the Hospital seventy percent (70%) of the value of the bad debts for allowable Medicare deductible and coinsurance amounts. This represents an opportunity for UMC to obtain additional Medicare reimbursement.

…UMC has not properly reported the Medicaid fraction in the Medicare DSH calculation.

As mentioned in the following section of the report, UMC has not properly reported the Medicaid fraction in the Medicare DSH calculation.

It does not appear that any investigation was performed to determine if related organization costs should be allocated to UMC as an adjustment to expense. These errors will skew the Hospital's cost to charge ratio (CCR).

Physician Part B costs and Physician charges were not properly excluded on the cost report. Under the Medicare cost to related organizations principle, the cost of ownership of an asset used in the Medicare program is includable in allowable cost of a hospital, even though it is owned by a related party. Typically, a government owned hospital will have related organization costs related to the government's cost related to the operation of the hospital. It does not appear that any investigation was performed to determine if related organization costs should be allocated to UMC as an adjustment to expense. These errors will skew the Hospital's cost to charge ratio (CCR). As mentioned herein, the CCR is used in the DSH audit tool and will be used in the calculation of the OBRA limit. Further the hospital-specific CCR is used in the calculation of outlier payments.

Our recommendations for the Hospital are as follows:

- Send a letter to Highmark requesting a change in the cost reporting year end from December 31 to September 30. Establish and document good cause for the change in the letter.
- Hire an independent cost report consultant to prepare the terminating cost report for the cost reporting period ended July 8, 2010, and prepare another cost report for the stub period from July 9, 2010 through December 31, 2010. The independent consultant should follow established Medicare cost finding principles, create the DSH listings for the two fiscal year 2010 cost reports, and work with UMC to create the Medicare bad debt logs.
- The independent cost report consultant should write the procedures for PFS to follow in the preparation of the Medicare bad debt logs. Typically, these logs are prepared monthly by PFS, so that the Medicare receivable can be properly accrued. These procedures should ensure that the Medicare bad debt logs include all of the data required by the Medicare regulations to be considered an allowable Medicare bad debt for deductible and coinsurance amounts.

Medicare Cost Report – Medicare Disproportionate Share Payment (DSH)

We reviewed the same Medicare cost report described above to determine whether UMC has properly utilized the cost report to calculate the Medicaid fraction included in the fiscal year 2010 Medicare DSH calculation. Based on the results of our review, we estimated an increase/decrease in Medicare DSH payments.

According to the independent consultant who prepares the cost report, the patient specific DSH listing to support the fraction was not provided because it was never prepared.

The cost report reflects that a Medicaid fraction of 34.93% was used in the DSH calculation. According to the independent consultant who prepares the cost report, the patient specific DSH listing to support the fraction was not provided because it was never prepared.

The Hospital received approximately $3.3 million in Medicare operating DSH payments related to the fiscal year ended December 31, 2010. Per the cost report, the sum of the Medicaid fraction of 34.93% and the SSI percentage of 18.93% equals 53.86%. Per Exhibit F, after this percentage is processed through the DSH formula, the DSH payment percentage is 33.65%. The payment percentage is applied to Medicare operating payments to determine the DSH payment. UMC also received approximately $100,000 in Capital DSH.

The independent cost report consultant stated that the Medicaid fraction used in the cost report was based on the Medicaid days reported on Worksheet S-3 of the cost report and was from the “Trended Stats Utilization” report. The total patient days from Worksheet S-3 of the cost report were compared to the “Trended Stats

Utilization" report and did not agree. The total patient days were 27,039 on the cost report. Both the "Trended Stats Utilization" report and the 2010 DSH collection tool reflect 31,009 patient days. The Medicaid days (including exempt units) included in the 2010 DSH collection tool are 14,798, compared to 10,770 (including exempt units) on the cost report. Medicare exempt units are excluded from both the numerator and the denominator of the Medicaid DSH fraction.

UMC has not properly reported the Medicaid fraction in the DSH calculation. Further work will need to be performed to determine the increase or decrease in Medicare DSH payment.

Exhibit F reflects a comparison of the DSH computation used in the submitted Medicare cost report and the DSH computation using the patient days reflected in the "Trended Stats Utilization" report. The "Trended Stats Utilization" report reflects an increase of approximately $600,000 over the as submitted report.

UMC has not properly reported the Medicaid fraction in the DSH calculation. Further work will need to be performed to determine the increase or decrease in Medicare DSH payments.

Our recommendations for the Hospital are as follows:

- Verify that the patient days report in the "Trended Stats Utilization" report agree to the census at the Hospital. It is important that total patient days are accurate, as they are the denominator in the Medicaid fraction.
- Secure capable resources knowledgeable about cost reporting preparation and filing, with DSH experience, to prepare the DSH listing for the fiscal year 2010 cost report and, if appropriate, file an amended cost report. Typically, the preparation of the DSH listing is a priority in the completion of the cost report because it represents a real opportunity to ensure that all available DSH reimbursement is claimed on the cost report.
- It is important to ensure that all Medicaid eligible days are included on the DSH list, including labor and delivery days, Medicaid Out-of-State days, Medicaid HMO, Medicare Part B only days, and Medicaid eligible days where Medicaid is the secondary or tertiary insurer and the patient does not have Medicare Part A days.

Fiscal Year 2011 Medicaid DSH Calculation

The two major questions related to determining if UMC will be allowed to keep the DC Medicaid fiscal year 2011 DSH payments are:

- What is UMC's Omnibus Budget Reconciliation Act (OBRA) limit for fiscal year 2011?
- Is the data included in UMC's 2010 DSH data collection tool reported accurately?

Answers:

- The OBRA limit is estimated to be $15 million for fiscal year 2011.
- The data included in the DSH data collection tool does not appear to be accurately reported. The major flaw in the tool is the calculation of the ratio of cost to charges.

UMC does not appear to have an OBRA limit issue for fiscal year 2011.

UMC does not appear to have an OBRA limit issue for fiscal year 2011. If DC Medicaid does not revisit the fiscal year 2011 DSH computations, no DSH payments paid by DC Medicaid should be retroactively disallowed. If they do, we believe the worse-case scenario would be an estimated $3.7 million retroactive disallowance.

The OBRA of 1993 imposed facility-specific ceilings on the amount of DSH payments that the States could make to DSH hospitals. The facility-specific ceilings are often referred to as the OBRA limit. This limit on the amount of payment to hospitals is contained in Section 1923(g) of the Social Security Act. The facility-specific OBRA limit caps the Medicaid DSH payment to the cost incurred of furnishing hospital services (net of Medicaid payments and payments by uninsured patients) to individuals who either are eligible for Medicaid under the State Plan or who have no health insurance (or other source of third party coverage) for services provided during the year. Payments made to a hospital for indigent patients by a state or local government program outside of the Medicaid program (i.e., the Alliance program) are not considered a source of third party payment in the OBRA calculation. These hospital-specific DSH limit calculations must comply with the federal DSH rules (42 CFR 447, Subpart E and 42 CFR 455, Subpart D). In December 2008, CMS published a Final Rule related to DSH payments, which included modifications to 42 CFR Parts 447 and 455.

A SPA related to a major change in the calculation of the DSH payments (New DSH) was effective July 3, 2010 and thereafter. The DSH data collection tool (tool) was developed by the DHCF to be used in the calculation of the New DSH.

The previous DSH payment methodology (Old DSH) was based on the fiscal year 2004 Medicare DSH payment percentage multiplied by the fiscal year 2004 Operating Medicaid DRG and Medicaid HMO Operating payments. The two factors that drive the Medicare DSH payment percentage are the ratio of Medicaid patient days to total patient days and the ratio of Medicare patients who were entitled to both Medicare Part A and were eligible for SSI benefits to total Medicare Part A patients. Based on this calculation of the Old DSH, UMC's fiscal year 2010 DSH allotment allocation was 10.05% of the private DSH pool.

For fiscal year 2011, DHCF originally based their DSH calculations on the 2008 DSH tool. Using the 2008 tool, UMC's New DSH allotment

allocation was calculated as 27.1%. Based on DC Medicaid's preliminary fourth quarter fiscal year 2011 DSH computation using the 2010 DSH data collection tool, UMC's fiscal year 2011 DC Medicaid DSH allotment allocation would be increased from 27.1% to 40.3%. Currently, the 2010 DSH data collection tool was used for the last quarter of the fiscal year 2011 DSH computation and the 2008 tool was used in the first three quarters of fiscal year 2011.

Under the Old DSH, UMC's DSH payments for fiscal year 2010 were approximately $4.9 million. Under the New DSH, using the 2008 tool for the first three quarters and using the 2010 tool for the last quarter, UMC's fiscal year 2011 DSH was calculated by DHCF as approximately $14.9 million.

The DSH tool, prepared by UMC personnel, was reviewed for accuracy. It was determined that using data for the twelve months ended June 30, 2011 would be appropriate to further test the reasonableness of the DSH data collection tool for the twelve months ended December 31, 2010, and could also be used to estimate UMC's OBRA limit for the fiscal year ended September 30, 2011. Therefore, a data download of all patient claims for the twelve month period ended June 30, 2011 was obtained from the Hospital. This download included patient level charge detail by revenue code, financial class, insurance plan, payments, and other miscellaneous data fields. A new 2010 tool and the OBRA limit were calculated using this data.

The DSH tools for both 2010 and 2008 were obtained from DHCF. A meeting was held with representatives from DHCF to discuss the 2010 DSH tool and how it was used in the fiscal year 2011 DC Medicaid DSH computation, and to discuss the incorporation of the updated DC Medicaid DRG rates effective April 1, 2010 into the computation. It was discussed how the incorporation of the 2010 DSH tool for the entire fiscal year 2011, and the inclusion of the retroactive Medicaid payments related to the APDRG rate adjustments would substantially change the allocation of available DSH funds and may cause some hospitals in the DSH pool to exceed their OBRA limit. Any monies recouped due to the OBRA limit would then be redistributed to hospitals in the pool that are under the OBRA limit.

Therefore, the $14.9 million is right at the ceiling and it is unlikely that UMC would benefit from an OBRA redistribution.

The fourth quarter fiscal year 2011 DSH payments were made in September 2011. UMC received approximately $14.9 million. Based on discussions with DHCF, it does not appear that the fiscal year 2011 DSH calculations will be revised to make changes in the tool data, to incorporate the APDRG adjustments, or to use the 2010 tool for the entire New DSH year, rather than just the last quarter. However, District hospitals are subject to the OBRA limit ceiling and adjustments will be made to the New DSH, redistributing any monies recouped due to this ceiling. It is estimated that the UMC's OBRA limit will be approximately $15 million for fiscal year 2011. Therefore, the $14.9

million is right at the ceiling and it is unlikely that UMC would benefit from an OBRA redistribution.

All other factors remaining the same, the recalculation of the data using a proper cost to charge ratio, based on the Medicare cost report, would reduce the DSH payment from $14.9 to an estimated $13.2 million, using the 2010 tool for the fourth quarter only, and an estimated $11.2 million, if the revised 2010 tool were used for the entire fiscal year 2011.

The results of the review of the fiscal year ended December 31, 2010 tool prepared by UMC revealed the following:

- Gross charges by financial class were obtained from the general ledger. The source documents were tested and it appears that the charges by financial class reflected in the tool agree to the general ledger.
- The cost report cost to charge ratio was calculated as follows:
    a. Gross inpatient and outpatient charges by financial class were obtained from MEDITECH
    b. Admissions by financial class were obtained from the "Trended Statistical Utilization" Report
    c. Adjusted admissions by financial class were calculated based on the average charge per admission
    d. The total hospital costs were allocated to inpatient and outpatient financial classes based on admissions and adjusted admissions
    e. Bad debt expense was included in total costs and was allocated between inpatient and outpatient bad debt
    f. The overall cost to charge ratio developed from steps a. through e. was 48.4%
- The patient days by financial class were obtained from the "Trended Statistical Utilization" Report
- The patient visits by financial class were obtained from MEDITECH
- The patient payments by financial class were obtained from the BAR receipts report in MEDITECH. The payments were split 85% to inpatient and 15% to outpatient for DC Medicaid 70% to inpatient and 30% to outpatient for Managed Care Medicaid and 40% to inpatient and 60% to outpatient for Alliance. There is no documentation supporting the split between inpatient and outpatient payments.

One of the challenges in UMC's calculation of the CCR is that the total costs include bad debt expense. Bad debt is not considered an

allowable cost under Medicare principles and is really a deduction from revenue. Not only does the calculation include bad debt expense in the total costs, it then adds bad debt expense again in step 2e above. The actual allowable cost of UMC was $81.4 million. The Hospital included another $28.6 million, or a total of $112.5 million, in the calculation of the CCR.

Using patient receipts from BAR does not properly match patient charges and receipts. The patient charges are accrual based charges and the patient receipts are cash based. The allocation of the patient receipts between inpatient and outpatient is based on an estimate.

The method used by the Hospital, described above, yielded a CCR of 48.4% and a DSH allotment allocation of 40.3%. The average CCR, calculated from the submitted fiscal year ended December 31, 2010 Medicare cost report is 30%. Using the Medicare CCR would reduce the DSH allotment allocation from 40.3% to 22.2%. A more refined method for calculating the CCR is based on departmental revenue codes. This method was performed as part of this review and is described below.

The Revenue Code CCR method would reduce the DSH allotment allocation from 40.3% to 21.1%.

A cost center specific, inpatient and outpatient, CCR by financial class, was calculated. The Hospital provided a patient specific download of all claims. This download included revenue code detail by patient. The revenue codes were summed for both inpatient and outpatient charges by financial class. These revenue codes were then cross-walked to the appropriate cost center grouping on the Medicare cost report. The CCR was applied to both the inpatient and outpatient charges by cost center for each of the financial classes. The Revenue Code CCR method would reduce the DSH allotment allocation from 40.3% to 21.1%.

Exhibit G compares the results of each of the three methods. The impact on costs included in the DSH tool is a reduction of approximately $28 million in DC Medicaid, DC Medicaid Managed Care, Alliance, and Uncompensated Care cost, and $27.3 million for the Medicare CCR and the Revenue Code CCR.

A complete DSH Audit Report was prepared following the regulations in the December 2008 DSH audit rule and following DSH Audit guidelines published by CMS on their website. This report was prepared using all patient specific claims from July 1, 2010 through June 30, 2011. This report was prepared two ways; 1) using paid claims only and 2) using both paid and unpaid claims. The DSH audit rule dictates that only paid claims can be used for insured patients. However, it is reasonable to assume at this point that some of the claims will be subsequently paid and used in the final OBRA limit calculation. This report calculates claim cost by revenue code. Based on the results of this report it is estimated that the fiscal year 2011 OBRA limit for UMC will be approximately $15 million.

Our recommendations for the Hospital are as follows:

There are no instructions for the completion of the tool. It is recommended that DHCF develop instructions for the tool so that all hospitals are using a consistent methodology when completing the form.

- There are no instructions for the completion of the tool. It is recommended that DHCF develop instructions for the tool so that all hospitals are using a consistent methodology when completing the form. It is recommended that the cost of Medicaid, Alliance, and Uninsured patients are determined using Medicare cost report methodologies. The claims data should be revenue code specific and mapped to the Medicare cost center. The ratio of cost to charges on Worksheet C can be applied to each of the cost center specific charges. Instructions should be provided to clarify that only paid claims are used in the cost determination. Further, the payments and days included in the tool should directly match the patient charges used in the cost determination.

It is recommended that the cost of Medicaid, Alliance, and Uninsured patients are determined using Medicare cost report methodologies.

…it is suggested that the District have the hospitals complete a new tool for fiscal year 2010 and recalculate the fiscal year 2011 Medicaid DSH payments.

- Due to the problems with the DSH tool and recognizing that the fiscal year 2010 DSH tool does not incorporate the retroactive APDRG payments effective April 1, 2010, it is suggested that the District have the hospitals complete a new tool for fiscal year 2010 and recalculate the fiscal year 2011 Medicaid DSH payments. This recalculation should provide us the fiscal year 2010 DSH data for the entire fiscal year 2011. This tool would include appropriate instructions and forms. A sample of suggested instructions and the forms were provided to the DHCF.
- UMC should hire an independent consultant who understands Medicare cost finding methodologies to prepare future DSH tools.
- UMC should engage a knowledgeable consultant who understands the Audit DSH rule and OBRA limit calculations to work on any data requests from the independent DSH auditors and to review any calculations that the DSH auditors prepare related to UMC's OBRA limit.

Exhibit A: UMC Business Model Options

Variable	Current State : Hospital Centric	Option 1: Ambulatory and Physician Centric(A & PC)	Option 2: A & PC Focus With Scaled Down Acute In Patient Services	Option 3: Total Facility Mgmt. Contract with Services To Be Determined	Option 4: Lease	Option 5: Sale
Ownership	District of Columbia	District of Columbia	District of Columbia	District of Columbia	District of Columbia enters into a lease to a third party who assumes responsibility for operations of and capital investments in UMC while ownership remains with the District of Columbia.	NFPHC is sold by the District of Columbia
Tax Status	Non-profit 501 c(3) organization	Non-profit 501 c(3) organization	Non-profit 501 c(3) organization	Non-profit 501 c(3) organization	Non-profit 501 c(3) organization	Non-profit or for-profit, depending on the party which purchases the NFPHC.
Governance	Separate Not-for-Profit Hospital Board with Semi-Autonomy	Separate Not-for-Profit Hospital Board with Semi-Autonomy	Separate Not-for-Profit Hospital Board with Semi-Autonomy	Separate Not-for-Profit Hospital Board with Semi-Autonomy	Governance supplied by the leasing party.	Assumed by the acquiring party.
Management	CEO and most C-Suite personnel are employees of UMC. The EVP, VP of Quality and Director of Patent Financial services are interim	The Board will need to decide on management competencies needed to successfully implement this	The Board will need to decide on management competencies needed to successfully implement this	Three to five year Total Facility Management Contract with an existing District operating health system, hospital	Minimum of a five year lease. Leasing party will provide the management team to operate UMC. This may or may not include	Leadership is likley to be changed out and replaced by the acquiring party.

Variable	Current State : Hospital Centric	Option 1: Ambulatory and Physician Centric(A & PC)	Option 2: A & PC Focus With Scaled Down Acute In Patient Services	Option 3: Total Facility Mgmt. Contract with Services To Be Determined	Option 4: Lease	Option 5: Sale
	appointments under contracts which vary from $300,000 to $400,000 and are inclusive of professional fees and out-of-pocket expenses. Due to Home Rule Act, UMC CFO reports to the DC Office of the CFO with a dotted line to the UMC CEO.	Option. The least amount of change is to keep the current leadership, but only if the Board and District leadership agree that the talent is present to implement in a timely and successful manner. Other options are to enter into a three to five year transition contract with an existing District health system, hospital management company or a transition firm which could supply some or all of the appropriate C-suite staff to include the CEO, CFO, CNO, COO, CMO, etc.	Option. The least amount of change is to keep the current leadership, but only if the Board and District leadership agree that the talent is present to implement in a timely and successful manner. Other options are to enter into a three year transition contract with an existing District health system, hospital management company or a transition firm which could supply some or all of the appropriate C-suite staff to include the CEO, CFO, CNO, COO, CMO, etc.	management company or a transition firm. Operator would supply the appropriate C-suite staff to include the CEO, CFO, CNO, COO, CMO, etc.	some or all of the existing leadership team.	

Variable	Current State : Hospital Centric	Option 1: Ambulatory and Physician Centric(A & PC)	Option 2: A & PC Focus With Scaled Down Acute In Patient Services	Option 3: Total Facility Mgmt. Contract with Services To Be Determined	Option 4: Lease	Option 5: Sale
Outsourcing vs. Internal Mgmt.	A number of key functions are outsourced. These include: IP Psych program, Ped's ED, Womens Health components, facilities and bio-medical engineering.	The C-Suite leadership or a contracted Operator would make recommendations to the functioning Board as to those services and functions which are best outsourced or brought in house.	The C-Suite leadership or a contracted Operator would make recommendations to the functioning Board as to those services and functions which are best outsourced or brought in house.	The Operator would make recommendations to the Board as to those services and functions which are best outsourced or brought in house.	Determined by the leasing entity.	Determined by the new owner
Strategic Plan	While current management has submitted their vision in January 2011, it has not been adopted by the Board nor has an alternative plan been developed. The Board Committees, including Strategic Planning, have been recently established but no draft has been created as of Oct 1, 2011.	A Tactical Plan will be created by the Board and Managment within 90 days to shut down the acute inpatient portion of the Hospital. This will take place concurrently while initial steps are taken to preserve cash, improve the revenue cycle, evaluate the FTE count and the span of control for the Management ranks. In addition, negotiations with an FQHC to establish	A Tactical Plan will be created by the Board and Managment within 90 days to scale down the acute inpatient portion of the Hospital. The SNF would be phased out as patients are relocated to other hospitals and/or SNF's in the area. This will take place concurrently while initial steps are taken to preserve cash, improve the revenue cycle, evaluate the FTE	A Strategic Plan will be created by the Board and Management within the first 90 days. This will take place concurrently while the initial steps are taken to preserve cash, improve the revenue cycle, evaluate the FTE count and the span of control for the Management ranks.	The leasing company will be required to present a Strategic Plan along with a business plan and present both to the District Dept. of Health and the District Council for ratification and attesting to the provision of basic health services needed by the people of Wards 7 and 8.	The new owner will be required to present a Strategic Plan along with a business plan and present both to the District Dept. of Health and the District Council for ratification and attesting to the provision of basic health services needed by the people of Wards 7 and 8.

Variable	Current State : Hospital Centric	Option 1: Ambulatory and Physician Centric(A & PC)	Option 2: A & PC Focus With Scaled Down Acute In Patient Services	Option 3: Total Facility Mgmt. Contract with Services To Be Determined	Option 4: Lease	Option 5: Sale
		a substantial presence on the UMC campus will begin immediately.	count and the span of control for the Management ranks. In addition, negotiations with an FQHC to establish a substantial presence on the UMC campus will begin immediately.			
Scope of Services	IP (adult M/S, intensive care, telemetry unit, womens health to include LDR's), SNF, closed/locked IP psych unit,narrow out-patient services, ED (adult and peds), imaging services, limited surgery capabilities.	Receive the approval of the District Dept. of Health and the CON body to suspend the IP acute care operations of UMC. The organization would concentrate on developing a robust ambulatory site, continue with a full service ED, improve the emergency patient transport system, introduce an FQHC on the campus designed to transform the primary care	With a population of 140,000 in Wards 7 and 8, and stong market share, the national average of 2.6 beds per 1,000 population would yield a need for 364 beds. Weak market share does not support this # of beds. Over 3 years, downsize the in patient activity to 60 M/S beds, OB, 23 hr. observation beds and an ICU. IP surgery, diagnostic imaging, laboratory and other ancillaries to support inpatient	Extensive business plans will be developed to determine the viability of existing and proposed scope of services and be responsive to the Rand Report, and a community primary care advisory Board which will be constituted to obtain input from the community at large and those in the ambulatory healthcare community, as to services which are needed by Wards 7	The lease may detail the minimum scope of services which the District will require to be provided on behalf of the population residing in Wards 7 and 8. Sevices beyond this minimum will be at the discretion of the leasing entity.	The sale provisions may stipulate a certain base level of services to be provided by the new owner for at least a five to ten year period. After that time frame, the new owner would be free to reconfigure the scope of services.

Variable	Current State : Hospital Centric	Option 1: Ambulatory and Physician Centric(A & PC)	Option 2: A & PC Focus With Scaled Down Acute In Patient Services	Option 3: Total Facility Mgmt. Contract with Services To Be Determined	Option 4: Lease	Option 5: Sale
		medical community in Wards 7 and 8, develop the surgical and medical sub-specialities with practices based in Wards 7 and 8, open a 23 hour observation unit and develop a birthing center. Over time, as UMC builds its reputation and Wards 7 and 8 increase access to services, re-open acute care beds, first with an ICU, followed by two 30 bed medical/surgical units opening in approximately three years.	services will be resized based upon demand. As community confidence grows and the medical staff is expanded, they may re-open additional acute M/S beds. Expand ambulatory services consistent with the Rand Report. Shutter balance of the beds including the SNF. Discontinue the Prisoner contract with Unity Health.	and 8.		
Market Segments	Male and female, pediactics, elderly, prisoners.	Males and females, pediatrics, elderly.	Males and females, pediatrics, elderly.	To be determined by the Board of NFPHC upon recommendation of the operator.	To be determined by the leasing party, but only after presenting its recommendations to the District Dept. of Health, District Council and Wards	

Variable	Current State : Hospital Centric	Option 1: Ambulatory and Physician Centric(A & PC)	Option 2: A & PC Focus With Scaled Down Acute In Patient Services	Option 3: Total Facility Mgmt. Contract with Services To Be Determined	Option 4: Lease	Option 5: Sale
					7 and 8 community primary care advisory Board.	
Geographic Focus	Wards 7 and 8 within the District, and passively accept patients from Maryland (specifically Prince George's County).	Wards 7 and 8 within the District, and passively accept patients from Maryland (specifically Prince George's County).	Wards 7 and 8 within the District, and passively accept patients from Maryland (specifically Prince George's County).	Wards 7 and 8 within the District, and passively accept patients from Maryland (specifically Prince George's County).	Depending on the scope of services, focus will continute to be on traditional communities, and will expand beyond the traditional Wards 7 and 8 based upon location of patients that access the product lines which are introduced into the market place.	
Payor Sources	Commerical, Medicare, Medicaid, Champus, Self pay, Managed Care	Commerical, Medicare, Medicaid, Champus, Self pay, Managed Care	Commerical, Medicare, Medicaid, Champus, Self pay, Managed Care	Commerical, Medicare, Medicaid, Champus, Self pay, Managed Care	Commerical, Medicare, Medicaid, Champus, Self pay, Managed Care	
Physician Integration	Employed CMO, contracts for: hospitalists, adult ED doctors, pathologist, radiologists, anesthesthia, medical directors and on call	Enter into a partnership with an FQHC to expand the quality and quantity of the primary care physicians in the community. This success will attract	Enter into a partnership with an FQHC to expand the quality and quantity of the primary care physicians in the community. This success will attract	All physician contracts and employment agreements will be reviewed and be modified, terminated or expanded once the Governing body	To be determined by the leasing party.	To be determined by the new owner.

Variable	Current State : Hospital Centric	Option 1: Ambulatory and Physician Centric(A & PC)	Option 2: A & PC Focus With Scaled Down Acute In Patient Services	Option 3: Total Facility Mgmt. Contract with Services To Be Determined	Option 4: Lease	Option 5: Sale
	arrangements for ED back-up. Primary care physicians, medical sub-specialists and surgeons are largely in private practice. Medical office building on campus leases space to physicians.	medical sub-specialities and surgeons to practice in the community and slow or reverse the outwards migration of people in Wards 7 and 8.	medical sub-specialities and surgeons to practice in the community and slow or reverse the outwards migration of people in Wards 7 and 8.	has received the recommendation of the operator.		
Vertical vs. Horizontal Integration	The UMC operates an acute IP and OP hospital, a SNF, and acute IP psych. No other hospital is part of NFPHC (UMC), nor services such as home health, durable medical services, physician group, managed care plan, accountable care organization, shared laundry, or OP pharmcy exist.	The short term strategy is to shift from a "hospital centric" campus to a "physician and ambulatory centric" campus.	While maintaining a scaled down inpatient presence, the 3 year strategy is to shift the focus to ambulatory care and grow the medical community. We do not recommend UMC continue the SNF as it serves to distract management from the transformation of the organization to being a ambulatory and physician centric medical campus.	The need for capital to fuel either vertical or horizontal integration makes it unlikely that significant expansion in either direction will take place. In fact, a contraction of services may be recommended if it will result in a more stable organization from a financial view point.	Leasing party will determine if they are willing to invest the capital necessary to expand either vertically or horizontally. The longer the lease the more likely the leasing party will make the investment so they are able to achieve a return on the invested capital.	To be determined by the new owner.

Exhibit B: Product Line Information

Product Line		Women's & Infant Health	Pediatrics	Wound & Hyperbaric Clinic	Infectious Diseases	Minimally Invasive Vascular	Diabetes & Obesity	Behavioral Health	ED	Radiology
Strategic	Statement/Goals									
	Metric Goals									
	Financial Pro-Forma									
Capabilities	Staff									
	Facilities/ Technology									
	Partners									
Volume/Trend										
Financial Management	2011 Budget									
	Monthly Actual									
Medical Staff	Leadership									
	Referral Base									
	Growth Potentials									
Process Improvement										
Multi-Disciplinary										
Growth & Outreach Activities/ Awareness	Market Share Information									
	Competitor									
	Actions									
Key			Established		Partial		Inadequate		Not Available	

Exhibit C: Charge Structure Review

United Medical Center -Adequacy of Charge Structure

Cost to Charge Ratio comparison - District Hospitals – Fiscal Year 2010

Hospital	United Medical Center	Washington Hosp. Center	Providence	Howard	Georgetown	Median	UMC CCR <High>/Low
Cost Report Year End	12/31/2010	6/30/2010	6/30/2010	6/30/2010	6/30/2010		
Med/Surg	66.36%	43.87%	52.27%	75.03%	45.91%	52.27%	-26.96%
ICU	47.79%	42.38%	51.80%	55.35%	50.88%	50.88%	6.07%
Psych	63.40%	42.84%	-	-	63.96%	63.40%	0.00%
Nursery	237.57%	20.61%	32.01%	53.67%	38.77%	38.77%	512.77%
OR	52.09%	34.18%	57.44%	45.46%	26.41%	45.46%	14.58%
RR	21.30%	32.48%	28.30%	75.40%	33.48%	32.48%	34.42%
LDR	94.42%	32.51%	45.82%	352.71%	52.97%	52.97%	-78.25%
Anesthe	45.95%	54.71%	20.49%	36.21%	20.84%	36.21%	-26.90%
Xray	19.86%	18.37%	19.00%	29.71%	13.75%	19.00%	-4.53%
Nuc Med	28.08%	28.79%	68.50%	21.63%	32.26%	28.79%	2.47%
Lab	13.23%	19.25%	25.08%	17.99%	11.99%	17.99%	26.46%
Blood	99.99%		52.28%	27.87%	33.39%	42.84%	-133.43%
O2	15.96%	28.71%	31.26%	9.45%	23.44%	23.44%	31.91%
PT	99.90%	29.65%	45.34%	31.93%	24.01%	31.93%	-212.87%
OT	53.04%	33.10%	55.74%	81.65%		54.39%	2.48%
ST	92.26%		52.45%	84.61%		84.61%	-9.04%

Exhibit D: Payments to Managed Care

United Medical Center
Managed Care Contracts Review

Source: Claims with a primary insurance of "HMO"
Claims with dates of discharge/service from September 1, 2010 to August 31, 2011

	Aetna US Healthcare	Kaiser	United Healthcare* 74080	Total all HMO
Paid Inpatient Charges	1,822,766	880,619	1,106,824	5,035,297
Unpaid Inpatient Charges	465,671	32,556	87,661	1,154,440
Billed Inpatient Charges	2,288,437	913,175	1,194,485	6,189,737
Paid Outpatient Charges	2,046,536	1,977,396	1,386,408	7,589,568
Unpaid Outpatient Charges	231,480	82,253	234,207	1,169,157
Billed Outpatient Charges	2,278,016	2,059,649	1,620,615	8,758,725
Total Paid Charges	3,869,302	2,858,015	2,493,232	12,624,865
Total Unpaid Charges	697,151	114,809	321,868	2,323,597
Total Billed Charges	4,566,453	2,972,824	2,815,100	14,948,462
% of Paid HMO Charges	31%	23%	20%	100%
% of Unpaid HMO Charges	30%	5%	14%	100%
%of Total Billed HMO Charges	31%	20%	19%	100%
Total Inpatient Payments	421,823	831,359	313,078	1,975,624
Total Outpatient Payments	506,730	1,946,754	437,409	3,906,203
Total Payments	928,553	2,778,113	750,487	5,881,827
% of IP Payment to Paid Charges	23%	94%	28%	39%
% of OP Payment to Paid Charges	25%	98%	32%	51%
% of total Payment to Paid Charges	24%	97%	30%	47%
Contract Effective Date	07/01/2009	XXXXXX	XXXXXXX	

Exhibit E: Skilled Nursing Facility Sample

Resident Identifier
A000061
A000101
A000105
A000038
S000077
A000035
A000087
A000093
A000118
N00042

Exhibit F: Medicare DSH

United Medical Center
Provider Number 05-0128

December 31, 2010
Disproportionate Share Payment Factor Calculation

	As Filed	Per Stat Report *
SSI Percentage	0.1893	0.1893
Total Medicaid Days	**7,753**	**10,452**
Total Days*	22,195	24,685
Medicaid Proxy Percentage	0.3493	0.4234
Total Percentage	0.5386	0.6127
Less Qualification Percentage	0.2020	0.2020
Balance	0.3366	0.4107
Times 82.5%	0.277695	0.3388275
Add: .0588	0.0588	0.0588
DSH Adjustment Factor	0.3365	0.3976
DRG Operating Payments	9,676,685	9,676,685
Total Medicare Operating DSH	3,256,205	3,847,450
*Includes Medicaid Pending		

Exhibit G: Medicaid DSH Payment

Fiscal Year 2011 DC Medicaid DSH Payment
CCR Comparison - DSH Tool Fiscal Year 2010

	A Submitted 484 CCR	B MCD CR 300 CCR	Increase/ <Decrease> B-A	Rev Code CCR	C Rev Code CCR	Increase/ <Decrease> C-A
Inpatient						
DC Medicaid	21,483,180	13,316,021	(8,167,159)	0.456	20,240,728	(1,242,452)
DC Medicaid Managed Care	6,711,098	4,159,771	(2,551,327)	0.523	7,251,832	540,734
Alliance	2,823,368	1,750,021	(1,073,347)	0.370	2,157,047	(666,321)
Uncompensated Care	1,393,995	864,046	(529,949)	0.469	1,351,739	(42,256)
Total Inpatient	32,411,641	20,089,860	(12,321,781)	0.470	31,001,347	(1,410,294)
Outpatient						
DC Medicaid	10,588,684	6,563,234	(4,025,450)	0.205	4,478,219	(6,110,465)
DC Medicaid Managed Care	16,074,095	9,963,282	(6,110,813)	0.191	6,343,203	(9,730,892)
Alliance	4,473,656	2,772,927	(1,700,729)	0.225	2,077,334	(2,396,322)
Uncompensated Care	10,194,912	6,319,160	(3,875,752)	0.179	3,760,596	(6,434,316)
Total Outpatient	41,331,347	25,618,604	(15,712,743)	0.194	16,659,352	(24,671,995)
Total						
DC Medicaid	32,071,864	19,879,255	(12,192,609)	0.365	24,171,120	(7,900,744)
DC Medicaid Managed Care	22,785,193	14,123,054	(8,662,139)	0.268	12,611,667	(10,173,526)
Alliance	7,297,024	4,522,949	(2,774,075)	0.280	4,214,624	(3,082,400)
Uncompensated Care	11,588,907	7,183,207	(4,405,700)	0.228	5,459,614	(6,129,293)
Total	73,742,988	45,708,464	(28,034,524)	0.331	46,457,025	(27,285,963)

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