



**METROPOLITAN GOVERNMENT OF
NASHVILLE AND DAVIDSON COUNTY**

OFFICE OF INTERNAL AUDIT

Professional Audit and Advisory Service

FINAL REPORT

Follow-Up Audit of Nashville General Hospital

Date Issued: March 2, 2009

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*The Metropolitan Nashville Office of Internal Audit is an independent audit agency
reporting directly to the Metropolitan Nashville Audit Committee*

Executive Summary March 2, 2009

Results in Brief	Recommendations									
<p>We performed a follow-up audit of Nashville General Hospital. Key audit objectives and conclusions follow:</p> <ul style="list-style-type: none"> To determine if specific recommendations outlined in the performance audit of Nashville General Hospital, issued February 22, 2005, which includes a performance assessment conducted by <i>Ernst and Young LLP</i>, have been implemented by Nashville General Hospital? <p>Generally, yes. Although two recommendations are still in the implementation process.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>Status</th> <th>Number</th> <th>Percent</th> </tr> </thead> <tbody> <tr> <td>Implemented</td> <td style="text-align: center;">16</td> <td style="text-align: center;">89%</td> </tr> <tr> <td>Partial</td> <td style="text-align: center;">2</td> <td style="text-align: center;">11%</td> </tr> </tbody> </table> <p>Additionally, other issues noted during our follow-up audit resulted in two new observations and recommendations.</p>	Status	Number	Percent	Implemented	16	89%	Partial	2	11%	<p>New recommendations of this report are for the Metropolitan Nashville Hospital Authority to:</p> <ul style="list-style-type: none"> Enhance governance and risk management practices by ensuring agreements between Nashville General Hospital and Vanderbilt University Medical Center are subject to review by the Metropolitan Nashville Hospital Authority Board of Trustees for reasonableness as to financial and operational requirements. Request Meharry to provide FY 2007 and FY 2008 documentation supporting monthly coverage as required by the PSA for the cardiology and orthopedics specialties. The resulting information should be used as a basis to quantify a refund claim for services not provided by Meharry. Additionally, NGH should ensure the NEW PSA quarterly documentation requirements are reviewed for compliance with contract terms. <p>Management's response can be seen on page 20 and 21.</p>
Status	Number	Percent								
Implemented	16	89%								
Partial	2	11%								

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INTRODUCTION

BACKGROUND

Nashville General Hospital (NGH) has over a 100 year history that began as a city hospital located near downtown Nashville. It is now governed by the Metropolitan Nashville Hospital Authority, which was created in March 1999. The Metropolitan Nashville Hospital Authority Board of Trustees consists of seven members, each serving five year terms. They are appointed by the Mayor and confirmed by a majority of the Metropolitan Government of Nashville and Davidson County (Metro) Council. NGH is currently located on the Meharry Medical College campus.

The mission of NGH is a publicly supported, academically affiliated, community-based hospital. They are committed to providing excellent healthcare regardless of age, race, creed, gender, sexual preference or ability to pay. With the alliance and collocation of Meharry Medical College the medical staff and employees provide an educational and research environment based on the provision of comprehensive and compassionate, acute care services for those in need. Meharry Medical College and Vanderbilt University formed the Meharry-Vanderbilt Alliance in 1999, a not-for-profit, private development foundation created to support the clinical, medical, education, research and training initiatives in a joint collaboration between Meharry Medical College and Vanderbilt University Medical Center.

In 2004, the Metro Internal Audit Section, formerly under the Department of Finance, engaged Ernst and Young LLP to complete a performance assessment of Nashville General Hospital. In addition to the work conducted by Ernst and Young LLP, the Internal Audit Section, reviewed procedures and internal controls surrounding financial and other operations and noted certain issues that needed to be addressed. The observations and recommendations noted in the report can be found in the *General Hospital Performance Audit* report of February 25, 2005, by using the Metro Office of Internal Audit's (OIA) website.¹ In February 2005, the then Chief Executive Officer of NGH stated in her response letter that NGH agreed to "initiate those internal recommendations that we have not already implemented."

The basis for this follow-up audit is to ascertain whether the recommendations made in the previous audit have been implemented.

SERVICES

NGH is licensed to provide 150 staffed beds and provides its patients with a highly trained medical staff, which includes community physicians as well as those from Meharry Medical College and to a limited degree, physicians from Vanderbilt University Medical Center. NGH offers a technologically advanced breast health center, cardiac catheterization lab, emergency department, medical imaging and several medical clinics specializing in dermatology,

¹ Office of Internal internet site: http://www.nashville.gov/internal_audit/fiscalyear_reports/2005.htm

gastroenterology, internal medicine, orthopedics, urology and others. The Outpatient Infusion Center at NGH offers a comprehensive line of intravenous therapies ranging from cancer chemotherapy to blood transfusions and various infusion therapies.

NGH also offers financial counselors who are available within the hospital to determine patient eligibility in the Health Services Certification Program. The Health Services Certification Program provides financial relief to those who are unable to meet financial obligations at NGH, also known as “charity care.” The certification process is based on specific criteria such as income levels at or below the federal poverty level and proof of residency in Davidson County. TennCare eligibility representatives are available at the hospital to determine eligibility for Medicare, TennCare, or other programs.

PAYEE MIX

TennCare patients are primarily traditional Medicaid patients who are either on public assistance or have low incomes and are disabled, pregnant or under 19. Many patients that were previously insured by TennCare became ineligible due to the 2005 TennCare reform. Thus, those patients are no longer eligible and therefore have been reclassified as “self pay” within the payer mix categories. “Charity care” is a subset of the self pay category.

The table immediately below presents a breakdown of the payee mix based on gross charges at NGH for the fiscal years 2002-2007, while the next chart shows the percentage of gross charges from each category. Note that while the TennCare category has increased overall in terms of dollars, its percentage of gross charges has significantly decreased. Consequently, the percentages of patients at NGH in the self pay category, many of whom are charity care, have increased from 16.6 to 35.3 percent. This significant change in the payer mix means that NGH now treats a larger percentage of patients that are not viable paying customers than it treated prior to the previous audit. It should be noted that NGH states that it prides itself on providing “excellent healthcare” regardless of the recipient’s ability to pay.

Exhibit 1

Gross Charges by Payor Group for Nashville General Hospital (In Millions)						
Payer	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
TennCare	\$40.3	\$41.0	\$ 47.8	\$48.4	\$48.1	\$48.5
Medicare	15.9	16.3	17.4	19.3	18.2	17.3
BCBS*	1.7	2.0	1.6	3.3	2.8	2.8
Commercial	2.0	2.6	2.9	1.5	4.1	5.2
Other	11.9	13.8	15.4	18.4	18.6	25.1
Self Pay	14.3	21.8	33.7	34.8	45.2	54.0
Total	\$86.1	\$97.5	\$118.8	\$125.7	\$137.0	\$152.9

Source: Tennessee Dept. of Health 2002-2007 Joint Annual Reports *Blue Cross Blue Shield

Exhibit 2

Payee Mix - Percentage of Gross Charges						
Payer	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
TennCare	46.8	42.1	40.2	38.5	35.1	31.8
Medicare	18.5	16.7	14.7	15.4	13.3	11.3
BCBS	2.0	2.1	1.3	2.6	2.0	1.8
Commercial	2.3	2.7	2.4	1.2	3.0	3.4
Other	13.8	14.1	13.0	14.6	13.6	16.4
Self Pay	16.6	22.3	28.4	27.7	33.0	35.3

Source: Tennessee Dept. of Health 2002-2007 Joint Annual Reports

Depicted in exhibit 3 below are the self pay collection percentages for fiscal years 2004-2007. Because charity care charges are included in the self pay category, the charity care charges must be subtracted from self pay charges to arrive at true self pay charges in order to present the collection percentages as accurately as possible (charity care charges are 0% collected). Taken together, the percentage actually collected for the entire self pay category for 2007 was 2.7%. Stated implicitly, NGH received 2.7 cents on the dollar for the self pay category in 2007.

Exhibit 3

True Self Pay Collection Percentages at Nashville General Hospital					
Fiscal Year	Self Pay Gross Charges	Charity Care Gross Charges	True Self Pay Charges	Self Pay Net Revenue	Collection Percentage
2003	\$21,784,574	\$ 4,084,812	\$17,699,762	-	
2004	33,739,079	7,407,043	26,332,036	\$888,653	3.37
2005	34,789,723	8,434,399	26,355,324	1,136,131	4.31
2006	45,212,776	17,137,136	28,075,640	1,085,688	3.87
2007	54,005,028	21,703,595	32,301,433	1,463,369	4.53

Source: Tennessee Dept. of Health 2003-2007 Joint Annual Reports

Although the collection percentages are very low, they have increased in fiscal year 2007 as compared to fiscal year 2006. Self pay collection efforts are initiated at the registration process by way of placing self pay patients on a payment plan that usually requires a down payment. Self pay charges usually remain in pre-collections for 120 days before they are turned over to a collection agency. Some preliminary 2008 and early current year data suggests that NGH is making further improvement in this area.

Note: During the period that we conducted the field work for this follow-up audit, current year (2008) audited financial statements from NGH were not yet available.

OCCUPANCY RATE

The occupancy rates for NGH for fiscal years 2004 through 2007 are presented in the table below. A licensed bed is one the hospital holds a license to operate. Staffed beds represent the number of physically available beds in which hospital staff has on-hand to attend to patients that could potentially occupy the bed. Occupied beds are beds that are staffed and occupied by a patient.

For the purposes of this summary, the number of beds occupied represents the number of staffed beds that were physically occupied as of the last day of the Joint Annual Report, (June 30, 20xx). Interviews conducted with NGH management indicate that NGH has available capacity in which to treat additional patients. NGH also has additional available staffed beds. At the end of fiscal year 2007, NGH had 53% of its licensed beds and 40% of its staffed beds available and ready for patients.

Exhibit 4

Occupancy Rate for Nashville General Hospital				
	2004	2005	2006	2007
Licensed Beds	150	150	150	150
Staffed Beds	127	117	117	117
Occupancy (Last Day of JAR Report—except 04)	81	87	53	71
Occupancy Rate, Licensed Beds	54%	58%	35%	47%
Occupancy Rate, Staffed Beds	64%	74%	45%	61%

Source: Tennessee Dept. of Health 2004-2007 Joint Annual Reports

Exhibit 5

STATEMENT OF OPERATIONS
Statements of Revenues, Expenses and Changes in Net Deficit
For Years ended June 30, 2008, 2007, and 2006

	<u>2008</u>	<u>2007</u>	<u>2006</u>
Operating revenues:			
Net patient service revenue (net of provision for bad debts of \$37,360,710 in 2008, \$24,226,637 in 2007, and \$24,276,580 in 2006 respectively)	\$41,884,627	\$37,608,713	\$25,659,216
State of Tennessee essential access revenue	7,890,389	8,443,901	6,064,225
Other	<u>4,740,419</u>	<u>4,080,067</u>	<u>3,352,292</u>
Total operating revenues	<u>54,515,435</u>	<u>50,132,681</u>	<u>35,075,733</u>
Operating expenses:			
Professional care of patients	67,487,773	61,855,890	54,956,997
Household and property	5,945,814	5,787,138	6,002,051
Dietary	2,048,281	1,976,555	2,000,128
Administrative and general	14,908,566	13,883,524	13,273,562
Allocation under metropolitan government-wide cost allocation plan	2,695,522	2,299,500	2,160,625
Depreciation and amortization	<u>4,886,481</u>	<u>4,267,824</u>	<u>3,870,766</u>
Total operating expenses	<u>\$97,972,437</u>	<u>\$90,070,431</u>	<u>\$82,264,129</u>
Operating loss	<u>(43,457,002)</u>	<u>(39,937,750)</u>	<u>(47,188,396)</u>
Operating loss as a percent of revenues	80%	80%	134%
Non-operating revenues (expenses):			
Revenue from the Government	34,926,983	36,523,278	31,429,159
Revenue from Government - supplemental	0	0	50,000,000
Interest expense	<u>(3,541,556)</u>	<u>(3,667,909)</u>	<u>(3,527,845)</u>
Total non-operating revenues, net	31,385,427	32,855,369	77,901,314
Excess (deficiency) of revenues over expenses before capital contribution	(12,021,575)	(7,082,381)	30,712,918
Capital contribution from the Government	12,532	61,440	60,158
Capital grants	<u>1,500,00</u>	<u>0</u>	<u>0</u>
(Increase) decrease in net deficit	<u>(10,559,043)</u>	<u>(7,020,941)</u>	<u>30,773,076</u>
Net deficit, beginning of year	<u>(17,025,595)</u>	<u>(10,004,654)</u>	<u>(40,777,730)</u>
Net deficit, at end of year	<u><u>\$(27,584,638)</u></u>	<u><u>\$(17,025,595)</u></u>	<u><u>\$(10,004,654)</u></u>

Source: Audited Financial Statements for fiscal years 2008, 2007, and 2006.

RESULTS OF FOLLOW-UP AUDIT

The *General Hospital Performance Audit* report of February 25, 2005 contained recommendations for observations reported by Ernst & Young and the OIA. Some of those observations have already been discussed and some are no longer relevant. During the follow-up audit we determined that of the below eighteen items, sixteen were implemented and two were partially implemented.

Exhibit 6

Summary of Follow-Up Audit

	Implemented	Partially Implemented
Previous Recommendations (18)	16	2
Percent of Total	89%	11%

COST SAVING OPPORTUNITIES

Previous Observation: NGH utilizes only 25% of MedAssets available purchasing contracts.

Previous Recommendation: Optimize use of MedAssets contracts and monitor programs and overall utilization of MedAssets available contracts and discount programs.

Current Status: Implemented

NGH contracts with MedAssets, a group purchasing organization (GPO). GPOs negotiate and purchase medical supplies in bulk on behalf of client hospitals at generally lower prices than individual hospitals can negotiate. Based on our testing, we determined that the MedAssets utilization rate has increased significantly. We determined that the utilization rates for fiscal years 2005, 2006, and 2007 to be 72%, 72% and 71%.

Previous Observation: NGH's policy for holiday pay rate, at 2.5 times pay, is above industry norm.

Previous Recommendation: Consider a reduction in the holiday pay rate from 2.5 times pay to 1.5 times pay to come more in line with industry pay practices.

Current Status: Implemented

NGH no longer pays holiday pay at a rate of 2.5 times pay. They currently pay 1.5 times pay which is in line with industry pay practices.

Previous Observation: Overtime expense is approximately 8% higher in fiscal year 2004 compared to fiscal year 2003. Interviewees have identified scheduling and staffing processes as problem areas causing high overtime requirement.

Previous Recommendation: Analyze trends on overtime use by department. Evaluate overall staffing plans and modify as appropriate.

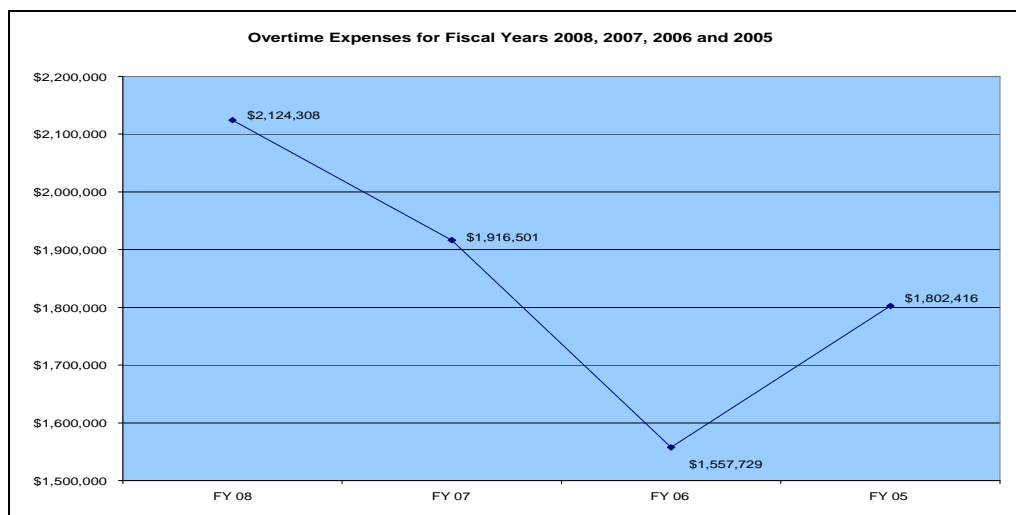
Current Status: Implemented

NGH has implemented biweekly and monthly overtime management monitoring reports.

Based on interviews with key personnel, minimizing overtime expense is challenging primarily due to a nationwide shortage of nurses. Along with a shortage of nurses it is also difficult to recruit well qualified experienced nurses at NGH. Exhibit 7 depicts overtime expense at NGH for fiscal years 2005, 2006, 2007, and 2008. Although overtime expense decreased significantly by 14% in 2006 as compared to 2005; it increased by 23% in 2007 when compared to 2006. This upward trend continued through 2008 when it increased by 11% when compared to 2007.

Several new initiatives are in the planning phase for recruiting nurses at NGH, including a job fair to highlight the benefits of working for the government, and bringing back retired nurses to work shorter shifts of twenty four hours a week.

Exhibit 7



Source: Metro EBS Accounting System.

Previous Observation: NGH has implemented portions of the 340B Federal drug discounting program. The program allows NGH to purchase certain outpatient drugs at discounted prices. Because the program is a federal program and available only to select hospitals, documenting compliance with the program is critical. Based on interviews with the pharmacy director, NGH has not fully implemented the 340B program.

Previous Recommendation: Evaluate and implement opportunities to optimize the program to realize cost savings. Develop policies and procedure to comply with program requirements (e.g., inventory management, billing.)

Current Status: Implemented

NGH has done a noteworthy job of increasing its utilization rate of the 340B program. For FY 2007, NGH purchased in excess of \$1.2 million through the 340B program, saving approximately 30% over comparable customer prices. The 340B federal program, managed by the U.S. Health Resources and Services Administration, requires that an all or none decision to participate in the program be made by the facility. Once a facility chooses to participate, it must order all of its meds through the program (required by law). If outages or time delays occur, then the facility may purchase the needed items elsewhere. NGH relies on the program manual for specific direction. The purchasing software utilized by the NGH Pharmacy automatically selects the 340B program as the first choice when ordering medications.

REVENUE OPPORTUNITIES

Previous Observation: Approximately 21% of NGH fiscal year 2003 total gross revenue was uncollectible self pay and considered charity care. A portion of these self pay patients may have qualified for TennCare but were not enrolled. By converting patients who qualify for TennCare rather than charity care, NGH could realize future annual revenues.

Previous Recommendation: Access success of current NGH TennCare enrollment processes including a review of viability of outsourcing the enrollment of TennCare eligible patients.

Current Status: Implemented

In 2005, NGH began contracting with *Med Assist*, a company that assists NGH in determining TennCare eligibility to those patients who may qualify. NGH has four MedAssist representatives onsite who work with patients to determine TennCare eligibility. Med Assist representatives review daily NGH census reports to determine patients who need to be screened. The representatives question the patients to determine if they qualify. For those patients who do qualify for TennCare benefits, there is a Department of Human Services employee onsite who will promptly initiate the TennCare paperwork. For calendar year 2007, approximately 65% of all patients screened for eligibility for TennCare were ultimately deemed eligible and successfully converted. While gross revenue from self pay patients has been influenced by many factors since the 2004 audit, NGH has done a sound job in this area. New FY 2008 and early FY 2009 figures initially indicate marked increases in outpatient conversions (to TennCare) and corresponding collections.

Previous Observation: The results of benchmarking indicate that NGH is below both its peers and industry norms in revenue cycle performance. For fiscal year 2004, average net days in accounts receivable was at 109.

Previous Recommendation: Evaluate methods for improving overall billing and collection efforts, including better use of electronic billing and remittance. Track progress of billing and collection efforts against new aggressive goals.

Current Status: Implemented

After an initial increase of 14% in net days in account receivables, NGH brought the metric back down to 82 days at the end of 2008. NGH believes they have viable reasons to see a continuation of improvement in this area.

Exhibit 8 illustrates the net days in accounts receivable for fiscal years 2005, 2006, 2007, and 2008. Net days in net accounts receivable represents the number of days it takes NGH to collect account receivable balances due from patient billings after all deductions which include, contract adjustments and allowances for bad debt.

Exhibit 8

<i>Days in Net Accounts Receivable</i>			
<i>Date</i>	<i>Days in A/R</i>	<i>Difference in Days</i>	<i>Percent Difference</i>
Average for Fiscal Year 2004	164		
Average for Fiscal Year 2005	187	23	14%
Average for Fiscal Year 2006	149	-38	-20%
Average for Fiscal Year 2007	90	-59	-40%
Average for Fiscal Year 2008	82	-8	-9%
Change in Days from FY 2004 to FY 2008		-82	-50%

Source: OIA Calculated from Audited Financial Statements for fiscal years 2008, 2007, 2006, 2005, and 2004.

Based on information obtained in the hospital's audited financial statements the days in net accounts receivable has decreased from 164 to 82 days or (50%) between fiscal years 2004 and 2008. According to discussions with NGH management, NGH is attempting to make additional improvements in net days in accounts receivable through initiatives outlined below:

MedAssist: By converting self-pay and or charity care patients to TennCare, NGH is able to collect on a higher percentage of its receivables. Med Assist also collects on self-pay pre-collections. Self-pay pre-collection efforts begin immediately after discharge or immediately after insurance final payment. Accounts typically remain in pre-collections for 120 days.

Payment America Systems: Collection agency utilized by NGH to work all receivable balances over 120 days. Payment America Systems will attempt to collect the outstanding balance for an indefinite period.

Claims Review Corporation: According to NGH management, contracts with the various insurers are often very complicated with each party paying different amounts for various services and procedures. In 2007, NGH implemented a new system called Pathways Contract Modeling (PMOD), a system that captures the details of these contracts. When a service is performed and billed, PMOD will calculate the expected revenue to be received based on the details of the contract with that particular insurer. When payment is received, PMOD will compare the amount received to the amount expected and facilitates identification of payer discrepancies.

Previous Observation: The revenue cycle metric “discharged not final billed” (DNFB) is a measurement of how many days it takes a facility to bill a claim once the patient has been discharged. As of May, 2004, DNFB days at NGH were over 27 days. The larger the DNFB days, the greater the cash flow constraint. A conservative target for DNFB days is 7 days. Based on interviews, it appears that physicians are the cause for the large DNFB days due to not completing their medical record chart documentation in a timely manner.

Previous Recommendation: Share cash constraint data with physicians along with detailed goals to reduce DNFB by attending physicians. Track and monitor improvement, and communicate improvements in cash flow with physicians, billing and collections, and medical records staff.

Current Status: Implemented

Exhibit 9 below illustrates the improvements made in decreasing DNFB days between May 2004 and August 2008.

Exhibit 9

Discharged Not Final Billed		
Time Period	Days	One Year Percent Decrease
May 2004	27.0	
Fiscal Year 2005	26.8	1%
Fiscal Year 2006	18.0	33%
Fiscal Year 2007	9.5	47%
August 2008	5.6	41%
Total Change	-21.4	80%

Source: NGH Dashboard Revenue Reports.

The information in the exhibit above, obtained from NGH revenue reports, indicates DNFB periods have decreased by 80% since May 2004. Interviews suggest the improvement is primarily due to NGH implementing a new imaging system used to electronically document medical records. The imaging system provides immediate access to records after scanning which

improves throughput for the coding team and availability for physician record completion. This system also allows copies of records requested by payers to be launched electronically, which improves turn around time for approval of payments. NGH also enhanced the editor function of its billing system whereby missing data causes a bill not to be submitted to insurers for payment until the appropriate information is entered. NGH also established a DNFB committee that met bi-weekly to monitor reports and follow-up with the specific individuals assigned. Additionally, the NGH Medical Staff Bylaws were updated two years ago to include stronger language for medical staff sanctions due to delinquent charts.

Previous Observation: Per management, manual processes for charge capture occur throughout the patient care areas due to the lack of/or antiquated systems. Certain interviewees explained that many staff believes there is no point in capturing charges since the patients are charity care and NGH will not get paid for these services.

Previous Recommendation: Assess charge capture processes and opportunities for improvement in all inpatient and outpatient areas. Develop improvement plans to improve charge capture processes in priority areas.

Current Status: Implemented

Exhibit 10 below reflects gross charges as reported in the *Tennessee Department of Health, Joint Annual Reports* for years 2002 through 2007.

Exhibit 10

Nashville General Hospital Gross Charges		
	Gross Charges	Percent Change
Fiscal Year 2002	\$ 86,195,502	
Fiscal Year 2003	97,561,452	13%
Fiscal Year 2004	118,825,399	22%
Fiscal Year 2005	125,774,460	6%
Fiscal Year 2006	136,900,654	9%
Fiscal Year 2007	152,882,155	12%
Change from 2002 to 2007	\$ 66,686,653	77%

Source: *Tennessee Dept. of Health 2002-2007 Joint Annual Reports*

Gross charges have increased at a steady rate during the period. The overall increase in gross charges from 2002 to 2007 was 77%. Since FY 2004 staffed bed occupancy rates of 64% are slightly higher, but roughly the same, as FY 2007 occupancy rates of 61% (since 10 more staffed beds were available in FY 2004), occupancy rates at NGH has remained fairly constant (does not include ER outpatients). Given that there is no indication of dramatically greater numbers of patients presenting at NGH, the resulting increases in gross charges are due to better charge capture procedures at NGH.

Previous Observation: NGH's charge description master (CDM or charge master) is manually maintained and updated. The CDM exists on many disparate information systems (e.g., finance, OR, pharmacy, purchasing). Updates to line items are not regularly reconciled between the many copies of the CDM throughout NGH. Duplicate codes exist. If the CDM does not contain a charge code or contains an incorrect charge code, the charge may not be captured and/or revenue may not be generated.

Previous Recommendation: Perform a comprehensive charge master assessment and update. Determine the need for multiple CDM's and implement a process to ensure update to all.

Current Status: Implemented

NGH contracted for an extensive review of the CDM. Subsequent to the review, the contractor continues to perform quarterly reviews of the CDM for accuracy and conformity to any new legislation or regulations.

Previous Observation: NGH does not have a contract management system to perform payor contract analysis. The ability to evaluate the payment terms of a payor or contract as it relates to the NGH profitability of that contract is extremely important. It is nearly impossible to determine if a contract will be or is profitable if an automated system is not utilized.

Previous Recommendation: Perform an assessment of available contract management systems and conduct a cost/benefit analysis of each potential system. Implement an improved contract management system that is identified to yield the greatest return under NGH's special payor requirements and payment practices.

Current Status: Implemented

In 2007, NGH implemented a new system called Pathways Contract Modeling (PMOD), a system that captures the details of contracts. When a service is performed and billed, PMOD will calculate the expected revenue to be received based on the details of the contract with that particular insurer. When payment is received, PMOD will compare the amount received to the amount expected and facilitates identification of payer discrepancies.

NGH is in the process of rolling out McKesson STAR Financials, an enterprise revenue management system designed to meet the needs of a hospital environment. The McKesson system has the ability to speed up current revenue cycle management, improve access management, accelerate cash collections, and improve payor performance. Included in this project is a second McKesson Pathways contract management system called "PCON." This revenue modeling product will allow payment variances to capture on printed reports and will also feed payment variances directly to a collectors electronic work list for resolution and follow-up.

OPERATIONAL EFFICIENCY OPPORTUNITES

Previous Observation: NGH has a high employee turnover rate, including a high management turnover rate. It is extremely difficult to achieve organizational goals, initiate change and demonstrate stability to employees when there is a high management turnover.

Previous Recommendation: Evaluate exit interview results and identify root causes for management and staff turnover.

Current Status: Implemented

NGH has continued to experience relatively high employee turnover rates since 2005. To help identify root cause for employee turnover, the Metropolitan Hospital Authority has a policy, "Separation of Service / Final Pay Check," which calls upon managers to conduct exit interviews when employees separate from NGH. We observed a sample of exit interviews conducted in 2008 and a summary analysis of resignation reasons for employee separations between January 2008 and October 2008. Additionally, the Metropolitan Hospital Authority has received a grant from the Baptist Healing Trust for the purpose of enhancing human resources capacities.

Exhibit 11

Fiscal Year	Employee Turnover
2005	18%
2006	31%
2007	25%

Source: NGH Annualized Turnover Report

Previous Observation: NGH's dependence on the Metro government for funding in excess of the subsidy. As a result of operating at a deficit, NGH has required operating cash support in addition to the Metro subsidy. Since the establishment of the Hospital Authority in 1999, NGH has had open ended access to Metro's cash to meet the operating requirements.

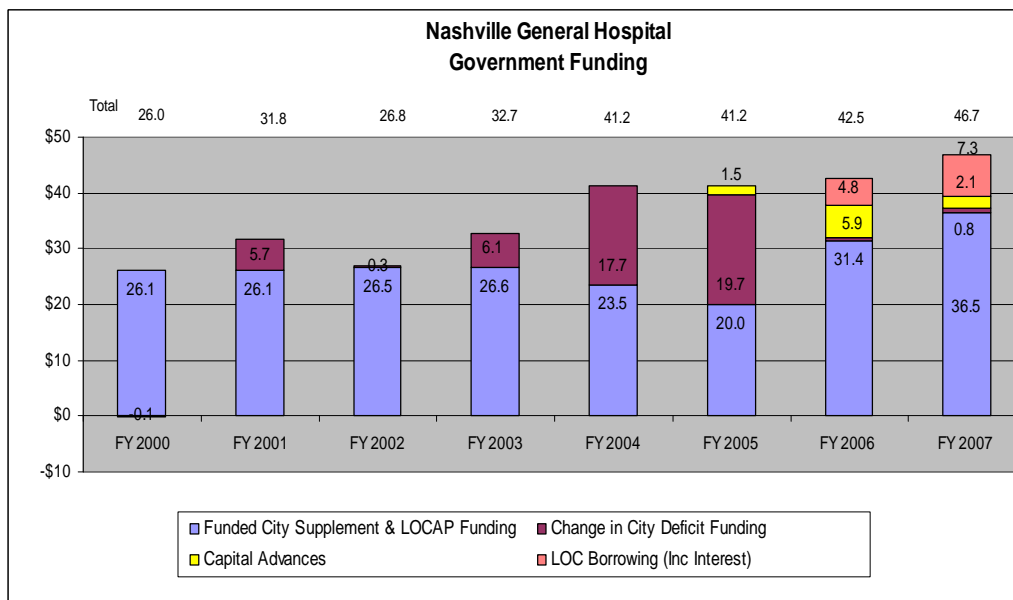
Previous Recommendation: NGH should establish its own independent bank account instead of having access to Metro's main operational bank account.

Current Status: Implemented

NGH established separate bank accounts in July 2005; but, did not have a system in place to process the hospital's vendor and/or payroll checks. These expenditures were still paid out of Metro's bank account and then subsequently reimbursed by NGH. However, in March 2007, NGH successfully took over the vendor payables function. As of the date of this report NGH does not yet have the capability to process its own payroll checks, which continue to be processed by the Metro Department of Finance. These payroll amounts are then reimbursed by NGH. Since the end of FY

2005, NGH has primarily received line of credit advance loans from Metro to supplement shortfalls of the subsidy, rather than outright increases to the subsidy (except for the \$50 million one time transfer in 2006, not included on below chart.)

Exhibit 12



Source: NGH Government Funding Report

Previous Observation: Improve purchase order (PO) process and security. The PO process, based on management and staff interviews, does not appear to be as controlled as is could/should be. Departmental managers are able to requisition, order, approve, and receive supplies.

Previous Recommendation: Assess security access to the materials management information system, to evaluate purchasing trends of all departments. Revise PO process to implement greater purchasing controls.

Current Status: Implemented

NGH has assessed the PO process and made changes so that proper approvals are now obtained. Additional process controls have been implemented such as segregation of duties, to provide separation of those who requisition, order, approve, and receive supplies so that no one person can act alone.

Previous Observation: NGH accounts payable staff spend their time re-keying entries into Metro’s system and the hospital system. Additionally, significant effort is required to reconcile NGH general ledger to Metro’s general ledger.

Previous Recommendation: NGH should consider using one general ledger. Staff reduction is a possibility if general ledger and journal entry functions are simplified.

Current Status: Implemented

NGH no longer uses the Metro accounting system and ledgers but has its own system and stand alone financials.

ALTERNATIVE FUNDING

Previous Observation: Alternative subsidy funding efforts have been limited. Through interviews and attendance at an NGH strategy planning session we found that NGH has had little activity surrounding the pursuit of alternative funds other than the receipt of the annual Metro subsidy payment. NGH has recently hired a person to pursue alternative funds such as philanthropy and grants for the hospital. Less than \$500,000 in grants has been received in a multi year period at NGH.

Previous Observation: "Friends in General", NGH's fundraising mechanism is listed as a tax exempt, non-profit organization. Historically, minimal funds have been generated by this fundraising organization. NGH has not developed and implemented a comprehensive fundraising plan.

Previous Recommendation: NGH should develop a comprehensive plan to pursue and attract philanthropic gifts both small and large. To do so, NGH will need to build a compelling development plan with incentives for donors.

Current Status: Partially Implemented

NGH through the efforts of the Friends In General Board were able to retain a full time grant writer in 2004. This initiative has resulted in NGH receiving approximately \$8.4 million in grant funds for the five year period 2004 through 2008 according to information furnished by NGH (this is in contrast to the \$500,000 received in a multi year period ending in 2004).

Additional philanthropic fund raising efforts to benefit NGH have had minimal results. The OIA did note that the "Friends in General" website had recently been updated (April 2008). It is now possible to donate to "Friends in General" via the internet.

The previous Metro Hospital Authority Board Chairman stated:

"It is difficult to raise money because they know we get money from the city and state."

The NGH Chief Executive Officer stated:

"We first had to fix ourselves internally, and we have done that. We have not yet tapped into the large donor market."

The NGH Chief Executive Officer related that 'Friends in General' struggle because potential donors may be unsure of the long term prospect of NGH and that the public nature of the yearly budget process and line of credit justification does more harm than good (concerning fundraising efforts).

MEHARRY MEDICAL COLLEGE RELATIONSHIP - Professional Services Agreement

Previous Observation: Current documentation of faculty and resident full time equivalents (FTEs) and activities is insufficient to reconcile actual versus the obligations set forth in the Professional Services Agreement (PSA). Service schedules do not provide sufficient detail to calculate FTEs. Meharry did not provide NGH with actual activity and staffing reports required contractually under the PSA. There is no definition of “FTE” in the PSA to determine, if documentation did exist, or what level of effort constitutes an FTE.

Previous Recommendation: NGH should define “FTE” and “Indigent” for the purposes of contract performance measurement and require Meharry to document services rendered per the terms of the PSA beginning with a detailed physician/house staff activity report for a current “typical” two-week period (to establish “comfort level”). Meharry should provide the required annual summary report of all faculty, resident and physician services in a format that would enable “reconciliation” of the PSA Staffing Plan. Meharry should provide the detailed, semi-annual accounting of Meharry's billing and collection activity as required by the PSA. This report should include service provided to, but not billed to Metro patients in order to understand the volume of services to Metro patients compared to Meharry's other clinical activities.

Requirements should be delineated which define specific Meharry obligations related to:

- Hospital/clinic coverage requirements (direct services).
- “Call” coverage requirements.
- Payer mix and volume issues.

Other requirements that should be defined include assessing whether PSA resources are being deployed to meet the needs of non-Metro patients, and assessing whether activity levels match FTE requirements and staffing levels (are budget adjustments, based on actual volume levels, appropriate and are such circumstances addressed)?

Current Status: Implemented

A New PSA was approved by Meharry Management in December 2008. This New PSA defines “FTE” and “Indigent” and contains requirements for Meharry to provide quarterly documentation to support provided physicians services. Additionally, a resolution agreement was entered into on April 1, 2007 whereby Meharry collaborated with NGH for facility, services, and technical services component fees

Prior to the New PSA, no action has taken place other than yearly changes to the staffing plan and increases to salary reimbursement levels. Activity and staffing reports have not been provided by Meharry and no verification process has been undertaken to determine actual services provided versus planned requirements or to determine if NGH is receiving what it pays for.

Discussion with NGH and Meharry employees indicate that shortfalls have been noted in some areas in services provided by Meharry in certain specialties. Test conducted by an independent third party confirmed service gaps for orthopedics and cardiology specialties during FY 2008.² The OIA estimates during FY 2008 NGH paid \$173,704 for services not provided by Meharry. This represents less than 2% of the PSA's total \$10.4 million in FY 2008 compensation provided to Meharry.

Previous Observation: According to NGH management, Meharry is billing and retaining some "Technical Services" payments from certain non-Metro patients treated in Metro facilities, which is in violation of PSA paragraph 11.3.

Reimbursements for evaluation and management services billed to patients are "global service" claims and include an allowance for "practice expenses" which is retained by Meharry although Nashville General incurs the technical component expenses for these services (supplies, space, overhead, etc.) when patients are treated at NGH. Unlike Medicare, most third party payers do not accept separate technical services claims from hospitals for services. Meharry should remit a portion of those services fees to NGH based on the Resource Based Relative Value System (RBRVS) practice expense for each claim.

Previous Recommendation: Meharry should remit a portion of those services fees to Nashville General based on the RBRVS practice expense for each claim.

Current Status: Partially Implemented

A resolution agreement was entered into on April 1, 2007 whereby Meharry Medical College agreed to pay \$298,350.53 to reimburse Nashville General for facility, services, and technical services component fees that NGH provided to patients between October 2002 and April 1, 2007. As of August 2, 2008 the full amount has been paid to NGH.

Additionally, Meharry and NGH forged an agreement in October 2007 that "Technical Service" fees earned by NGH but paid to Meharry, on or after April 1, 2007 shall be computed using a sliding scale RBRVS multiplier. However, as of August 1, 2008 Meharry had not remitted any of the past 16 months payment amounts to NGH.

Previous Observation: The PSA does not appear to address individual compensation levels for Meharry physicians other than the aggregate amounts budgeted for each service, though management states levels are based on the 25th percentile of surveys published by the American Association of Medical Colleges. Benchmarking commercial reasonability of compensation is appropriate, though limited compensation to the 25th percentile may have an adverse effect on physician recruitment.

² Meharry and the OIA agreed that the third party public accounting firm retained for yearly financials by Meharry would review the support (payroll and time records) related to the PSA agreement.

Management states position requirements and expectations for chiefs of service are delineated in NGH's Medical Staff Bylaws. Agreement to conform to this standard should be added to the PSA, or the PSA itself should reflect specific requirements and expectations.

Previous Recommendation: NGH should consider alternative methods to establish the resource requirements and appropriate funding levels for Meharry services which would improve documentation and accountability:

- Establish medical-administrative needs based on detailed position requirements, goals and objectives, time requirements, and market based compensation analysis.
- Purchase clinical services for Metro patients from Meharry on a fee-for-service basis (negotiated rates).
- Purchase on-call services based on a competitive market analysis and needs assessment.
- Consider employing "full time" physicians directly in administrative and/or clinical roles.
- Consider contacting with community physicians on a fee-for-service or hourly rate basis for direct services or on-call coverage as appropriate.

NGH should also establish a period documentation testing protocol to support Meharry payment for clinical, teaching and administrative activities (an internal audit approach) regardless of the established payment methodology.

Current Status: Implemented.

Individual compensation levels for Meharry physicians have been addressed. Management at NGH related that compensation levels are now at the 50th percentile, as opposed to the 25th percentile in 2004 (not independently verified by the OIA).

NGH Management stated that the NEW PSA staffing levels contemplated the appropriate staffing requirements to operate NGH twenty-four hours per day, seven days per week in an efficient, cost effective manner. Additionally, the NEW PSA includes provisions for quarterly documentation of services performed by Meharry, monthly invoice adjustments for non-availability of providers, and access to records to facilitate periodic contract compliance audits.

The New PSA was approved by Meharry Management in December 2008.

NEW OBSERVATIONS AND RECOMMENDATIONS

A –Board Review of Agreements with Vanderbilt University Should Be Improved

NGH Management was unable to provide any evidence of the Metropolitan Hospital Authority Board of Trustees prior approval for contracts between NGH and Vanderbilt University Medical Center (VUMC). VUMC is contracted by the Metropolitan Hospital Authority (MHA) to provide key management personnel at NGH including the Chief Executive Officer. The “Amended and Restated Management Services Agreement” (MSA) provides that the Chief Executive Officer shall have the right to: take possession of and endorse negotiable instruments on behalf of NGH, full signature authority of all NGH accounts, negotiate, enter into, terminate and administer contracts on behalf of NGH. To mitigate the perception or possibility of factual independence impairment the agreement also states any transaction between VUMC and NGH or Bordeaux be subject to the Authority’s prior approval.

The OIA believes MHA’s overall governance framework would be enhanced if contracts involving VUMC are reviewed by a third party outside of the Chief Executive Officer’s span of control.

Criteria

MSA section 4.8 – Transactions with VUMC or its Affiliates:

“Any transaction between VUMC or its affiliates and NGH or Bordeaux during the Term hereof shall be subject to the Authority’s prior approval which shall not be unreasonably withheld or delayed.”

According to the Metro Department of Law, the Metropolitan Nashville Hospital Authority acts through its Board of Trustees. Accordingly, any contract between VUMC and the Metropolitan Nashville Hospital Authority requires the Board of Trustees’ express approval and ideally should be evidenced by the signature of the Board’s chairperson.

Risk

Agreements between VUMC and NGH may be criticized or scrutinized because “checks and balances” control for transactions with publically perceived related parties are not functioning.

Recommendation

The Metropolitan Nashville Hospital Authority should enhance governance and risk management practices by ensuring agreements between Nashville General Hospital and Vanderbilt University Medical Center are subject to review by the Metropolitan Nashville Hospital Authority Board of Trustees for reasonableness as to financial and operational requirements. This review should be memorialized in the Metropolitan Hospital Authority meeting

minutes or the Board's chairperson signature on the contract review routing form.

Metropolitan Hospital Authority Response to Audit Recommendation

Management recommends to the Board of Trustees that the following additional steps be followed in the review and approval of agreements between the Metropolitan Hospital Authority and Vanderbilt University. Areas of consideration are as follows:

- Dollar threshold of annual expenditures;
- Review by Authority outside counsel and signature as to legality and form;
- Approval as evidenced by the appropriate signature of the Board Chairman or Vice Chairman in his absence; and
- Subsequent review and ratification by the Board of Trustees such review is then memorialized in the Authority Board meeting minutes.

B –Meharry Professional Service Shortages

The OIA estimates during FY 2008 NGH paid \$173,704 for services not provided by Meharry Medical Colleges. Tests conducted for five PSA service specialties indicated service gaps for orthopedics and cardiology specialties during FY 2008. ³ Meharry was unable to provide evidence of coverage for the following specialties.

Specialty	PSA Schedule A	November 2007	April 2008	June 2008
Orthopedics	2.4 FTE	0.85 FTE	0.85 FTE	0.85 FTE
Value of Shortage		\$10,271	\$10,271	\$10,271

Assuming the orthopedic specialty shortage was prevalent for the entire FY 2008, the value of this shortage would be \$123,250.

Specialty	PSA Schedule A	July 2007	September 2007	March 2008
Cardiology	3.0 FTE	1.0 FTE	1.0 FTE	-0- FTE
Value of Shortage		\$8,409	\$8,409	\$-0-

Assuming the cardiology specialty shortage was prevalent for the first half of FY 2008, the value of this shortage would be \$50,454.

Meharry provided adequate documentation to support coverage for the majority of the specialties tested. The total estimated shortage of \$173,704 represents less than 2% of the PSA's total \$10.4 million in FY 2008 compensation provided to Meharry.

The NEW PSA, finalized in December 2008, includes provisions for quarterly documentation of services performed by Meharry, monthly invoice adjustments for non-availability of providers, and access to records to facilitate periodic contract compliance audits.

³ Meharry and the OIA agreed that the third party public accounting firm retained for yearly financials by Meharry would review the support (payroll and time records) related to the PSA agreement.

Criteria

Amended and Restated Professional Services Agreement between NGH and Meharry Medical Colleges effective July 1, 2001. Schedule A – Staffing Plan FY 2007 – 2008.

Risk

Agreements between Meharry and NGH may be criticized or scrutinized because paid contractual service staffing coverage has not been provided in all medical specialties for all months.

Recommendation

NGH Management should request Meharry to provide FY 2007 and FY 2008 documentation supporting monthly coverage as required by the PSA for the cardiology and orthopedics specialties. The resulting information should be used as a basis to quantify a refund claim for services not provided by Meharry. Additionally, NGH should ensure the NEW PSA quarterly documentation requirements are reviewed for compliance with contract terms.

Metropolitan Hospital Authority Response to Audit Recommendation

Management recommends to the Board of Trustees that the PSA for the fiscal year beginning July 1, 2008 (the inception date of the new PSA) and thereafter during its duration include the following:

- Documentation supporting monthly coverage as required by the PSA be collected and reviewed for compliance with contract terms;
- A quarterly reconciliation of the cost of actual services provided compared to the agreed upon cost of proposed services in the PSA; and
- A monetary settlement sixty days after the end of each quarter during the term agreement, effective beginning with the two quarters ending December 31, 2008.

Management reconciled the FY2007 and FY2008 PSA performance and those years are deemed to be closed.

GENERAL AUDIT INFORMATION

STATEMENT OF COMPLIANCE WITH GAGAS

We conducted this follow-up audit from April to December 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our observations and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our observations and conclusions based on our audit objectives.

SCOPE AND METHODOLOGY

The audit period focused primarily on the period July 1, 2005 through June 30, 2007 financial balances, transactions and performance on the processes in place during the time of the audit. Certain analyses required the consideration of financial results, performance and operations outside that time period.

The methodology employed throughout this audit was one of objectively reviewing various forms of documentation, including written policies and procedures, financial information and various forms of data, reports and information maintained by the NGH administrative office. Management, administrative and operational personnel, as well as personnel from other Metro departments and other stakeholders were interviewed, and various aspects of the NGH were directly observed.

CRITERIA

In conducting this audit, NGH was evaluated for compliance with:

- Metro Substitute Resolutions 99-1410 and 99-1413
- Metro Internal Audit 2005 Performance Audit of NGH
- Metro Ordinance No. BL2007-1557
- Metro Department of Law Opinions and Guidance
- Committee of Sponsoring Organizations of the Treadway Commission, Internal Controls – Integrated Framework, Control Activities
- NGH Strategic Plan 2008

STAFF ACKNOWLEDGEMENT

Carlos Holt, CIA, CFE, CGAP - Audit Manager
Jane Terry - In Charge Auditor
Bill Walker, CPA – Staff Auditor
Tina Kennamore – Staff Auditor

APPENDIX A. MANAGEMENT ACKNOWLEDGEMENT

- Management's Acknowledgement Starts on Next Page -



Metropolitan

Nashville Hospital Authority

▶ Nashville General Hospital at Meharry ▶ Knowles Home Assisted Living & Adult Day Services ▶ Bordeaux Long-Term Care

February 18, 2009

Mark Swann
Metropolitan Auditor
Office of Internal Audit
222 3rd Ave. North, Suite 401
Nashville, TN 37201

Dear Mr. Swann,

This letter is to acknowledge receipt of the Audit report entitled, Follow-up Audit of Nashville General Hospital, which was conducted by the Office of Internal Audit.

We have reviewed the audit report and are in agreement with its findings. Therefore, we have begun implementation of the recommendations applicable to each finding. This audit will serve as a valuable instrument and management tool in our overall objective to enhance governance, risk management practices and revenue improvement.

We appreciate the professionalism of your staff during this engagement.

Sincerely,



Reginald W. Coopwood, MD, FACS
Chief Executive Officer

/cdb

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we care for YOU. for life.