DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL - 9 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Review of Touro Infirmary's Reported Fiscal Year 2005 Wage Data (A-01-08-00513)

Attached is an advance copy of our final report on Touro Infirmary's (the Hospital) reported fiscal year (FY) 2005 wage data. We will issue this report to the Hospital within 5 business days. This review is one of a series of reviews of the accuracy of wage data reported by five New Orleans hospitals. In August 2007, officials from these hospitals testified before the House Committee on Energy and Commerce regarding operating losses experienced after Hurricane Katrina struck the New Orleans area in 2005.

Under the inpatient prospective payment system for acute-care hospitals, Medicare Part A pays hospital costs at predetermined, diagnosis-related rates for patient discharges. The payment system base rate includes a labor-related share. The Centers for Medicare & Medicaid Services (CMS) adjusts the labor-related share by the wage index applicable to the statistical area in which a hospital is located. To calculate wage indexes, CMS uses wage data collected from hospitals' Medicare cost reports 4 years earlier.

Our objective was to determine whether the Hospital complied with Medicare requirements for reporting wage data in its FY 2005 Medicare cost report.

The Hospital did not fully comply with Medicare requirements for reporting wage data in its FY 2005 Medicare cost report. Specifically, the Hospital overstated its salaries by $605,419 and understated its hours by 4,168. Our correction of the Hospital's errors decreased the average hourly wage rate approximately 1.3 percent. The errors in reported wage data occurred because the Hospital did not sufficiently review and reconcile wage data to supporting documentation to ensure that all amounts reported were accurate, supportable, and in compliance with Medicare requirements. If the Hospital does not revise the wage data in its FY 2005 cost report, the FY 2009 wage index for the Hospital's statistical area will be overstated, which will result in overpayments to all of the hospitals that use this wage index.

We recommend that the Hospital:

- submit a revised FY 2005 Medicare cost report to the fiscal intermediary to correct the wage data errors that overstated salaries by $605,419 and understated hours by 4,168 and

- implement review and reconciliation procedures to ensure that the wage data reported in future Medicare cost reports are accurate, supportable, and in compliance with Medicare requirements.

In its written comments on our draft report, the Hospital agreed with our findings.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through e-mail at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-08-00513.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

JUL 14 2008

Report Number: A-01-08-00513

Mr. Robert A. Ficken
Chief Financial Officer
Touro Infirmary
1401 Foucher Street
New Orleans, Louisiana 70115

Dear Mr. Ficken:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Touro Infirmary's Reported Fiscal Year 2005 Wage Data." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact David Lamir, Audit Manager, at (617) 565-2704 or through e-mail at David.Lamir@oig.hhs.gov. Please refer to report number A-01-08-00513 in all correspondence.

Sincerely,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF TOURO INFIRMARY'S REPORTED FISCAL YEAR 2005 WAGE DATA

Daniel R. Levinson
Inspector General

July 2008
A-01-08-00513

Office of Inspector General

http://oig.hhs.gov

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Under the inpatient prospective payment system for acute-care hospitals, Medicare Part A pays hospital costs at predetermined, diagnosis-related rates for patient discharges. The Centers for Medicare & Medicaid Services (CMS) adjusts prospective payments by the wage index applicable to the area in which each hospital is located. CMS calculates a wage index for each metropolitan area, known as a core-based statistical area (CBSA), as well as a statewide rural wage index for each State. These calculations use hospital wage data (which include wages, salaries, and related hours) collected 4 years earlier to allow time for the collection of complete cost report data from all inpatient prospective payment system hospitals and for reviews of hospital wage data by CMS's fiscal intermediaries. For example, CMS will base the fiscal year (FY) 2009 wage indexes on wage data collected from hospitals' Medicare cost reports for their FYs that began during Federal FY 2005 (October 1, 2004, through September 30, 2005).

CMS bases each wage index on the average hourly wage rate of the applicable hospitals divided by the national average rate. A hospital's wage rate is the quotient of dividing total dollars (numerator) by total hours (denominator). Arriving at the final numerator and denominator in this rate computation involves a series of calculations.

CMS is required to update wage indexes annually in a manner that ensures that aggregate payments to hospitals are not affected by changes in the indexes. CMS is also required to update payments to hospitals by an applicable percentage based on the market basket index, which measures the inflationary increases in hospital costs. Hospitals must accurately report wage data for CMS to determine the equitable distribution of payments and ensure the appropriate level of funding to cover hospital costs.

Touro Infirmary (the Hospital) is a 248-bed, faith-based community teaching hospital in New Orleans, Louisiana. The Hospital is 1 of 24 hospitals in the New Orleans urban CBSA. The Hospital reported wage data of $55.2 million and 2.2 million hours in its FY 2005 Medicare cost report, which resulted in an average hourly wage rate of $25.19.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for reporting wage data in its FY 2005 Medicare cost report.

SUMMARY OF FINDINGS

The Hospital did not fully comply with Medicare requirements for reporting wage data in its FY 2005 Medicare cost report. Specifically, the Hospital reported the following inaccurate wage data, which affected the numerator and denominator of its wage rate calculation:

- unallowable home office fringe benefit costs totaling $473,789,
- unallowable pension costs totaling $131,849, and
- unreported severance hours that understated wages by $219 and 4,168 hours.

These errors occurred because the Hospital did not sufficiently review and reconcile its reported wage data to supporting documentation to ensure that the data were accurate, supportable, and in compliance with Medicare requirements. As a result, the Hospital overstated its salaries by $605,419 (numerator) and understated its hours by 4,168 (denominator) for the FY 2005 Medicare cost report period. Our correction of the Hospital's errors decreased the average hourly wage rate approximately 1.3 percent from $25.19 to $24.86. If the Hospital does not revise the wage data in its cost report, the FY 2009 wage index for the Hospital's CBSA will be overstated, which will result in overpayments to all of the hospitals that use this wage index.

RECOMMENDATIONS

We recommend that the Hospital:

- submit a revised FY 2005 Medicare cost report to the fiscal intermediary to correct the wage data errors that overstated salaries by $605,419 and understated hours by 4,168 and

- implement review and reconciliation procedures to ensure that the wage data reported in future Medicare cost reports are accurate, supportable, and in compliance with Medicare requirements.

TOURO INFIRMARY COMMENTS

In its written comments on our draft report, the Hospital agreed with our findings. The Hospital's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicare Inpatient Prospective Payment System

Under the inpatient prospective payment system for acute-care hospitals, Medicare Part A pays hospital costs at predetermined, diagnosis-related rates for patient discharges. In fiscal year (FY) 2008, the Centers for Medicare & Medicaid Services (CMS) expects Medicare Part A to pay inpatient hospitals approximately $120.5 billion.

Wage Indexes

The geographic designation of hospitals influences their Medicare payments. Under the inpatient prospective payment system, CMS adjusts payments through wage indexes to reflect labor cost variations among localities.[1] CMS uses the Office of Management and Budget (OMB) metropolitan area designations to identify labor markets and to calculate and assign wage indexes to hospitals. In 2003, OMB revised its metropolitan statistical area definitions and announced new core-based statistical areas (CBSA). CMS calculates a wage index for each CBSA and a statewide rural wage index for each State for areas that lie outside CBSAs. The wage index for each CBSA and statewide rural area is based on the average hourly wage rate of the hospitals in those areas divided by the national average hourly wage rate. All hospitals within a CBSA or within a statewide rural area receive the same labor payment adjustment.

To calculate wage indexes, CMS uses hospital wage data (which include wages, salaries, and related hours) collected 4 years earlier to allow time for CMS to collect complete cost report data from all inpatient prospective payment system hospitals and for CMS's fiscal intermediaries to review these data. For example, CMS will base the wage indexes for FY 2009, which will begin October 1, 2008, on wage data collected from hospitals' Medicare cost reports for their FYs that began during Federal FY 2005 (October 1, 2004, through September 30, 2005). A hospital's wage rate is the quotient of dividing total dollars (numerator) by total hours (denominator). Arriving at the final numerator and denominator in this rate computation involves a series of calculations. Inaccuracies in either the dollar amounts or hours reported can have varying effects on the final rate computation.

Section 1886(d)(3)(E) of the Social Security Act (the Act) requires that CMS update wage indexes annually in a manner that ensures that aggregate payments to hospitals are not affected by changes in the indexes. Hospitals must accurately report wage data for CMS to determine the equitable distribution of payments. Further, section 1886(d)(3)(A)(iv) of the Act requires CMS to update labor and nonlabor average standardized amounts by an applicable percentage increase specified in section 1886(b)(3)(B)(i). The percentage increase is based on the market basket index, which measures inflationary increases in hospital costs. The inclusion of unallowable

[1]The inpatient prospective payment system wage index or a modified version also applies to other providers, such as outpatient hospitals, long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, and hospices.

costs in wage data could produce an inaccurate market basket index for updating prospective payments to hospitals.

Touro Infirmary

Touro Infirmary (the Hospital) is a 248-bed, faith-based community teaching hospital in New Orleans, Louisiana. The Hospital is 1 of 24 hospitals in the New Orleans urban CBSA. The Hospital submitted to CMS its FY 2005 Medicare cost report covering the period January 1 through December 31, 2005.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital complied with Medicare requirements for reporting wage data in its FY 2005 Medicare cost report.

Scope

Our review covered the $55,152,338 in salaries and 2,189,235 in hours that the Hospital reported to CMS on Worksheet S-3, part II, of its FY 2005 Medicare cost report, which resulted in an average hourly wage rate of $25.19. We limited our review of the Hospital's internal controls to the procedures that the Hospital used to accumulate and report wage data for its cost report.

We performed our fieldwork at the Hospital in New Orleans, Louisiana, from November 2007 through January 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- obtained an understanding of the Hospital's procedures for reporting wage data;
- verified that wage data on the Hospital's trial balance reconciled to its audited financial statements;
- reconciled the total reported wages on the Hospital's FY 2005 Medicare cost report to its trial balance;
- reconciled the wage data from selected cost centers to detailed support, such as payroll registers or accounts payable invoices;
- interviewed Hospital staff regarding the nature of services that employees and contracted labor provided to the Hospital; and

- determined the effect of the reporting errors by recalculating the Hospital's average hourly wage rate using the CMS methodology for calculating the wage index, which includes an hourly overhead factor, in accordance with instructions published in the Federal Register.

We conducted this performance audit 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 findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The Hospital did not fully comply with Medicare requirements for reporting wage data in its FY 2005 Medicare cost report. Specifically, the Hospital reported the following inaccurate wage data, which affected the numerator and denominator of its wage rate calculation:

- unallowable home office fringe benefit costs totaling $473,789,
- unallowable pension costs totaling $131,849, and
- unreported severance hours that understated wages by $219 and 4,168 hours.

These errors occurred because the Hospital did not sufficiently review and reconcile its reported wage data to supporting documentation to ensure that the data were accurate, supportable, and in compliance with Medicare requirements. As a result, the Hospital overstated its salaries by $605,419 (numerator) and understated its hours by 4,168 (denominator) for the FY 2005 Medicare cost report period. Our correction of the Hospital's errors decreased the average hourly wage rate approximately 1.3 percent from $25.19 to $24.86. If the Hospital does not revise the wage data in its cost report, the FY 2009 wage index for the Hospital's CBSA will be overstated, which will result in overpayments to all of the hospitals that use this wage index.[2]

ERRORS IN REPORTED WAGE DATA

The errors in reported wage data are discussed below. We provided the Hospital with details on these errors and on our calculations under separate cover.

Unallowable Home Office Fringe Benefit Costs

The "Medicare Provider Reimbursement Manual" (the Manual), part II, section 3605.2, states that hospitals should ensure that the wage data reported in their Medicare cost reports are accurate. The Manual, part I, section 2144.1, states that fringe benefit amounts must be properly classified in the Medicare cost reports. In addition, the Manual, part I, section 2144.7, states that if "a provider does not charge the cost of fringe benefits directly to the department or cost center where the employee is assigned, then the cost reimbursement forms, which are used to determine

[2]The extent of overpayments cannot be determined until CMS finalizes its FY 2009 wage indexes.

Medicare reimbursement, provide the mechanism for the allocation of fringe benefits to the appropriate cost centers."

The Hospital uses an allocation methodology to allocate home office salaries and fringe benefit costs between the Hospital and its freestanding rehabilitation facility. The Hospital used the correct allocation methodology when recording its home office salaries. However, the Hospital used the wrong allocation methodology when recording its home office fringe benefit costs. Because it did so, the Hospital recorded as Hospital costs $473,489 in fringe benefit costs that should have been allocated to the freestanding rehabilitation facility. As a result, the Hospital overstated its wage data by $473,489, which overstated its average hourly wage rate by $0.22.

Unallowable Pension Costs

The Manual, part I, section 2142.3, states that "for a [pension] plan to be considered funded for the purposes of Medicare cost reimbursement, the liability to be funded must have been determined, and the provider must be obligated to make payments into the fund." Moreover, section 2142.6(A) states that a provider must "make payment of its current liability for both normal costs and actuarial accrued liability costs to the fund established for the pension plan in accordance with the provisions covering liquidation of liabilities." According to the Manual, part I, section 2142.5, normal costs are that portion of pension costs allocated to the current year and are allowable in the year accrued. Actuarial accrued liabilities are that portion of pension costs not provided for by current and future normal costs and generally must be amortized ratably over a minimum of 10 years. If a provider makes an excessive payment, i.e., a payment that is "more than the lesser of the tax-deductible maximum or the total normal cost plus ratable amortization of the unfunded actuarial accrued liability, the excess may be carried forward and considered as payment against the liability to the fund of the future period" (section 2142.6(C)).

The Hospital's cost report included $131,964 in pension benefit costs ($79,609 for Hospital employees and $52,355 for home office employees). However, the Hospital's pension plan was already fully funded. Because the plan's assets exceeded its normal costs plus its actuarial accrued liability, there was no liability to be funded, and the Hospital was not obligated to make payments to the fund. Therefore, any payments that the Hospital made during the period were excessive payments that could not be claimed for the audit period. By claiming these pension costs, the Hospital overstated its wage data by $131,849 after overhead was factored in, which overstated its average hourly wage rate by $0.06.

Unreported Severance Hours

The Manual, part II, section 3605.2, requires hospitals to record the number of paid hours corresponding to the amounts reported as wages and salaries, including amounts for severance pay. The section defines paid hours as including "regular hours (including paid lunch hours), overtime hours, paid holiday, vacation, and sick leave hours, paid time-off hours, and hours associated with severance pay."

The Hospital included a total of $483,000 in salaries for severance pay without reporting 4,160 in related hours. As a result, after overhead was factored in, the Hospital understated its wage data by $219 and 4,168 hours, which overstated its average hourly wage rate by $0.05.

CAUSE OF WAGE DATA REPORTING ERRORS

These reporting errors occurred because the Hospital did not sufficiently review and reconcile wage data to supporting documentation to ensure that all amounts included in its Medicare cost report were accurate, supportable, and in compliance with Medicare requirements.

OVERSTATED WAGE DATA AND POTENTIAL OVERPAYMENTS

As a result of the reporting errors, the Hospital overstated its salaries by $605,419 (numerator) and understated its hours by 4,168 (denominator) for the FY 2005 Medicare cost report period. Our correction of the Hospital's errors decreased the average hourly wage rate approximately 1.3 percent from $25.19 to $24.86. If the Hospital does not revise the wage data in its cost report, the FY 2009 wage index for the Hospital's CBSA will be overstated, which will result in overpayments to all of the hospitals that use this wage index.

RECOMMENDATIONS

We recommend that the Hospital:

- submit a revised FY 2005 Medicare cost report to the fiscal intermediary to correct the wage data errors that overstated salaries by $605,419 and understated hours by 4,168 and

- implement review and reconciliation procedures to ensure that the wage data reported in future Medicare cost reports are accurate, supportable, and in compliance with Medicare requirements.

TOURO INFIRMARY COMMENTS

In its written comments on our draft report, the Hospital agreed with our findings. The Hospital's comments are included in their entirety as the Appendix.

APPENDIX

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May 22, 2008

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203

Re: Report Number: A-01-8-00513

Dear Mr. Armstrong,

We have examined the draft report entitled "Review of Touro Infirmary's Reported Fiscal year 2005 Wage Data" and agreed to its findings. The necessary adjustments have been submitted to the Medicare Intermediary and were incorporated in their wage index review.

If you have any questions, please contact Sal Cardinale (504-897-8968) or Caroline Kain (504-897-8648).

Sincerely,

Robert A. Ficken
Chief Financial Officer

RAF/dmg

Touro Infirmary | 1401 Foucher Street | New Orleans, LA 70115 | ph: 504.897.7011 | fax: 504.897.8322 | www.touro.com