Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF VENDOR REBATES PAID TO HOSPITALS

CGH MEDICAL CENTER STERLING, ILLINOIS

Daniel R. Levinson
Inspector General

MAY 2007
A-05-07-00044

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all 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.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

May 14, 2007

Report Number: A-05-07-00044

Mr. Joseph L. Chamberlain
Vice President and Chief Financial Officer
CGH Medical Center
100 E. LeFevre Road
Sterling, Illinois 61081-1279

Dear Mr. Chamberlain:

This final report provides the results of our audit of a vendor rebate in the amount of $5,965 that a drug manufacturer paid to CGH Medical Center of Sterling, Illinois. We identified this rebate through a national statistical sample of rebates.

BACKGROUND

CGH Medical Center

CGH Medical Center (the provider) is an acute care facility located in the Rock River Valley region of northern Illinois. Inpatient services include a 45-bed medical unit, a 34-bed surgical unit, and a 12-suite birthing center.

Vendor Rebates

A vendor rebate is a retroactive discount, allowance, or refund given to a health care provider after the full list price has been paid for a product or a service. Rebates are usually paid quarterly or annually and are usually dependent on achieving a specific purchasing volume. A rebate is paid directly to a provider (e.g., a hospital) or to a nonprovider (e.g., a group purchasing organization or distributor).

Federal regulations (42 CFR § 413.98) state that rebates are reductions in the cost of goods or services purchased and are not income. The Centers for Medicare & Medicaid Services (CMS) "Provider Reimbursement Manual" (part 1, chapter 8) requires hospitals and other health care providers to report all discounts on their Medicare cost reports.

Medicare Cost Reports

Some types of Medicare-certified providers, such as hospitals, skilled nursing facilities, and home health agencies, must submit an annual Medicare cost report to a fiscal intermediary. The

cost report contains provider information, including facility characteristics, utilization data, costs and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. A cost center is generally an organizational unit having a common functional purpose for which direct and indirect costs are accumulated, allocated, and apportioned. Providers must reduce previously reported Medicare costs when they receive rebates.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the provider reduced costs reported on its 2003 Medicare cost report by the $5,965 vendor rebate it received.

Scope

As part of a national statistical sample of rebates that a single drug vendor sent directly to providers, we selected a $5,965 rebate that the provider received during calendar year 2003. We limited our review to identifying the rebate amount and determining whether the provider credited the amount in its accounting records and on its Medicare cost report. We did not perform a detailed review of the provider's internal controls.

We performed our fieldwork from October through November 2005 at the drug vendor's offices in Deerfield, Illinois. We requested and received information from the provider through phone contacts, mail, and electronic mail.

Methodology

To accomplish our objective, we:

- reviewed Federal regulations and CMS guidance related to rebates,
- obtained a statistical sample of rebates paid by the vendor to identify providers that received the rebates,
- requested documentation from the provider regarding the reporting of the rebate,
- determined whether the provider credited the sampled rebate amount on its Medicare cost report, and
- quantified the dollar amount of any rebates not reported and used to reduce previously reported costs.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

The provider did not reduce costs reported on its 2003 Medicare cost report by the $5,965 rebate, contrary to Federal regulations and CMS guidance. The provider did not report the rebate because it was misclassified. Instead of using the rebate to reduce its health care costs, the provider recorded the rebate in a revenue account that was not credited on its Medicare cost report. Providers must offset costs by rebates to ensure that they report the actual cost of services provided.

We recommend that the provider:

- revise and resubmit its 2003 Medicare cost report, if not already settled, to properly reflect the $5,965 rebate as a credit reducing its health care costs; and

- consider performing a self-assessment of its internal controls to ensure that future vendor rebates are properly credited on its Medicare cost reports.

PROVIDER COMMENTS

In its comments on the draft report, the provider agreed with our recommendations. The provider stated that in the future it will (1) ensure that their general ledger is reconciled, and (2) implement procedures to better identify rebates so they can be properly accounted for in their Medicare cost reports. The provider's written comments are included as the Appendix.

* * * * *

A copy of this report will be forwarded to the action official noted on the next 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 the HHS action official within 30 days. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with 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 are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please contact Jaime Saucedo at (312) 353-8693. Please refer to report number A-05-07-00044.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Regional Administrator
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

APPENDIX

100 E. LeFevre Road
Sterling, IL 61081-1279
(815) 625-0400
Fax: (815) 625-4825
Website:www.cghmc.com

April 4, 2007

Mr. Clemente Torres
U.S. Department of Health & Human Services
Office of the Inspector General
Office of Audit Services (Region V)
233 N. Michigan, Suite 1360
Chicago, Illinois 60601

RE:Proper Handling of Baxter Credit Memo 50544159 ($5,965.05) dated 1/28/03
Audit Report Office of Inspector General March 2007 A-05-07-00044

Dear Mr. Torres:

Per your request I am advising you of the tracking of the above referenced credit memo from Baxter through the CGH Medical Center Cost Report for the hospitals cost report year 2003. It is the hospitals policy to handle all rebates and incentive discounts in the manner prescribed under the Medicare rules and regulations. Unfortunately in this case the particular item was not handled appropriately.

The cost report in question was actually prepared by Strategic Reimbursement (3315 W. Algonquin Road Suite 110 Rolling Meadows, Illinois 60008) for 2003. The credit memo (incentive came as a credit memo and not a separate check) was appropriately taken against a valid invoice from Baxter but the amount was posted to a miscellaneous other operating revenue account in CGH Medical Centers general ledger. During the reconciliation between the hospitals general ledger and the Medicare Cost Reports trial balance small balances were not accounted for by Strategic Reimbursement because they were deemed immaterial.

In the future we will ensure that the consultants charged with preparation of our Medicare Cost Report reconcile our general ledger to the penny and that we put in place procedures to better identify incentives of this nature to be properly accounted for in the Medicare/Medicaid Cost Reports.

If you have any questions or need anything additional from me, please do not hesitate to contact me.

Joseph L. Chamberlain
VP & CFO
(815) 625-0400 (4413)