

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

REVIEW OF
VENDOR REBATES
PAID TO HOSPITALS

UNIVERSITY OF IOWA
HOSPITALS & CLINICS
IOWA CITY, IOWA



Daniel R. Levinson
Inspector General

MAY 2007
A-05-07-00049

Office of Inspector General

<http://oig.hhs.gov>

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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 15, 2007

Report Number: A-05-07-00049

Mr. Kenneth Fisher
Interim Associate Vice President for Medical Affairs and CFO
University of Iowa Hospitals & Clinics
E139 General Hospital
200 Hawkins Drive
Iowa City, Iowa 52242

Dear Mr. Fisher:

This final report provides the results of our audit of a vendor rebate in the amount of \$77,014 that a drug manufacturer paid to University of Iowa Hospitals & Clinics of Iowa City, Iowa. We identified this rebate through a national statistical sample of rebates.

BACKGROUND

University of Iowa Hospitals & Clinics

University of Iowa Hospitals & Clinics (the provider) is a 760-plus bed, university-owned hospital and an academic medical center that provides health care, medical research, and training for health care professionals.

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 2004 Medicare cost report by the \$77,014 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 \$77,014 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,
- quantified the dollar amount of any rebates not reported and used to reduce previously reported costs, and
- contacted the provider's fiscal intermediary to verify the accounting for the vendor rebate.

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

FINDING AND RECOMMENDATIONS

For the \$77,014 rebate reviewed, the provider did not reduce costs reported on its fiscal year 2004 Medicare cost report by \$70,056, contrary to Federal regulations and CMS guidance. The provider used \$76,293 of the \$77,014 rebate for the purchase of new equipment. The provider then amortized a portion (\$6,237) of the \$76,293 as depreciation expense on its 2004 Medicare cost report and deferred the remaining portion (\$70,056) for future cost reporting periods. The provider stated that it did not properly account for the credit memorandum in accordance with Medicare policy and that it has notified its compliance office and fiscal intermediary of this issue. 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 2004 Medicare cost report, if not already settled, to properly reflect the \$70,056 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 it (1) notified its fiscal intermediary who made an audit entry to correct the issue on the 2004 Medicare cost report and (2) conducted an audit to identify any material deposits or credit memos that were not recorded correctly. The provider's written comments are included as the Appendix.

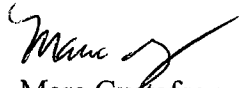
* * * * *

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-05-07-00049.

Sincerely,



Marc Gustafson
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Mr. Tom Lenz
Regional Administrator
Centers for Medicare & Medicaid Services
601 E. 12th Room 235
Kansas City, Missouri 64106

APPENDIX



University of Iowa Health Care

Department of Finance and Accounting Services

E139 General Hospital
200 Hawkins Drive
Iowa City, IA 52242
319-384-6557 Tel
319-353-6927 Fax

May 2, 2007

Mark Gustafson
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services – Regional Office
233 N. Michigan, Suite 1360
Chicago, IL 60601

RE: OIG Limited Scope Review of Rebates

Dear Mr. Gustafson,

In response to your letter dated April 18, 2007, below is our response to the recommendations.

Revise and resubmit the 2004 Medicare cost report:

Due to the fact that this particular credit memo was accounted for incorrectly, we notified our compliance office and our fiscal intermediary (Cahaba) of this issue. Cahaba auditors were on-site auditing the FY2004 Medicare Cost Report when this issue was identified. We discussed this issue with them while they were on site and they have made an audit entry to correct this issue. Attached is their proposed entry (Adjustment #A038). The FY2004 audit is completed and we are awaiting a final Notice of Program Reimbursement (NPR) from Cahaba.

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

After being notified of this issue via your audit, the UIHC conducted an audit to look for any material deposits or credit memos that were not booked correctly. The Baxter rebate in question was very unusual case since it was not received as a discount, allowance or refund but as a credit memo that could only be applied against the purchase of additional capital equipment from Baxter. This was the only company that we could find that "rebated" operating expenses as a credit memo that could only be used for future capital purchases.

Because of this issue, we have concluded that we will no longer accept proposals from vendors involving "credit memos" or other similar arrangements that require the application of credits from an expense transaction to a capital transaction.

Thank you for bringing this to our attention.

Sincerely,

A handwritten signature in black ink, appearing to read "Kenneth Fisher".

Kenneth Fisher
Interim Associate Vice President for Medical Affairs and CFO/UIHC

AUDIT ADJUSTMENT REPORT BY ADJUSTMENT NUMBER

Page:22

*** Listing of Adjustments (continued)
(>>) - Adjustments Excluded from Extract

Adj#	Worksheet	Component	Line	Column	Description / Cost Center	As Reported	Adjust. Amt.	As Adjusted
A036p	C pt 1		60.02	6	DERMATOLOGY CLINIC	6,704	41	6,745
	C pt 1		60.05	6	NEUROLOGY CLINIC	6,884	42	6,926
	C pt 1		60.07	6	OPHTHALMOLOGY CLIN	41,377	230	41,607
	C pt 1		60.15	6	FAMILY CARE CLINIC	18,532	114	18,646
	C pt 1		61	6	EMERGENCY	1,892,881	14,578	1,907,459
	C pt 1		60.02	7	DERMATOLOGY CLINIC	4,500,255	(41)	4,500,214
	C pt 1		60.05	7	NEUROLOGY CLINIC	1,618,927	(42)	1,618,885
	C pt 1		60.07	7	OPHTHALMOLOGY CLIN	7,444,699	(230)	7,444,469
	C pt 1		60.15	7	FAMILY CARE CLINIC	9,001,954	(114)	9,001,840
	C pt 1		61	7	EMERGENCY	18,548,922	(14,578)	18,534,344

Explanation: Reclass of total charges from total outpatient charges to total inpatient charges to ensure that inpatient Medicare charges do not exceed total inpatient charges.

Work Paper: 16A-26

Regulation: CMS Pub. 15-1, Section 2304

Adj#	Worksheet	Component	Line	Column	Description / Cost Center	As Reported	Adjust. Amt.	As Adjusted
A037	A (A8 - Basis A)		60.11	7	Adj # 37 Cost Center: SURGERY CLINIC	2,667,519	81,462	2,748,981
	A (A8 - Basis A)		85	7	Adj # 37 Cost Center: HEART ACQUISITION	640,731	(81,462)	559,269
	A8 - Basis A		60.11	2	Adj # 37 Cost Center: SURGERY CLINIC	0	81,462	81,462
	A8 - Basis A		85	2	Adj # 37 Cost Center: HEART ACQUISITION	0	(81,462)	(81,462)

Explanation: Adjust to properly state Heart Acq salary costs.

Work Paper: 21-4

Regulation: CMS Pub 15-1 Section 2304

Adj#	Worksheet	Component	Line	Column	Description / Cost Center	As Reported	Adjust. Amt.	As Adjusted
A038	A (A8 - Basis A)		4	7	Adj # 38 Cost Center: NEW CAP REL COSTS-	22,355,375	(6,358)	22,349,017
	A8 - Basis A		4	2	Adj # 38 Cost Center: NEW CAP REL COSTS-	0	(6,358)	(6,358)

Explanation: Adjust to remove non-allowable costs for Baxter credit memo.

Work Paper: 1-10

Regulation: CMS Pub 15-1 Section 413.98

University of Iowa
16-0058
6/30/2004

Purpose: Removal of costs associated with incentive discount
Source: Provider records
Scope: Removal of non-allowable expense from the MCR

Comment: In our pre exit conference it was noted that the provider had claimed costs that would be deemed non-allowable per 42CFR 413.98. We will adjust to remove the capitalized costs in the CY and subsequent years.

Conclusion: The adjustment completes the work here.

C 7/10/06

Total Costs to be capitalized	76,293
Useful life 120 months	<u>120</u>
	636 Monthly depreciation expense

Adjustment calculation

FYE	# Months	Adjustment Amount
2004	10	(6,358)
2005	12	(7,629)
2006	12	(7,629)
2007	12	(7,629)
2008	12	(7,629)
2009	12	(7,629)
2010	12	(7,629)
2011	12	(7,629)
2012	12	(7,629)
2013	12	(7,629)
2014	2	(1,272)
Total	<u>120</u>	<u>(76,293)</u>

Adjustment

W/S	Cost Center	Line	Col	Amount
A	MME	4	7	(6,358)

1-10