Memorandum

Date JUL 23 2002

From Janet Rehnquist
Inspector General

Subject Medicare Inpatient Hospital Prospective Payment System Discharges Improperly Reported and Paid After Hospital Consolidations (A-06-00-00044)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's (OIG) final report entitled, "Medicare Inpatient Hospital Prospective Payment System Discharges Improperly Reported and Paid After Hospital Consolidations." We initiated this review as part of our continuing audit work related to prospective payment system (PPS) transfers. Our prior reviews identified significant overpayments related to Medicare inpatient hospital PPS transfers incorrectly reported as discharges. Our current review focused on such incorrectly reported transfers at the time of or after PPS hospital consolidations.

The objectives of our review were to (1) determine whether claims were improperly submitted to the fiscal intermediaries (FI) after two or more PPS hospitals consolidated to form a single Medicare provider and (2) quantify any Medicare overpayments for these improperly submitted claims.

A consolidation of hospitals is considered a change of ownership by Medicare regulations. These regulations require that Medicare payments for services to patients who are discharged after the date of the consolidation be made to the legal owner on the date of discharge. After a consolidation, only the surviving hospital (Medicare provider) would be entitled to the Medicare payments, because it was the legal owner on the date of discharge.

As of June 30, 1998, 15 hospitals that ceased to exist after consolidation with another hospital were paid for 1,118 PPS discharges that should not have been billed to Medicare. To date, as a result of actions taken or planned to address claims and/or cost report issues arising from the 15 consolidations:

- FIs have recovered nearly $300,000 related to two consolidations and have begun recovery actions related to two additional consolidations;
- The Department of Justice has reached settlements totaling nearly $3.2 million related to five consolidations; and

- The OIG has identified claims overpayments of more than $4.5 million for 6 of the 15 consolidations and will make appropriate referrals to FIs for recovery.

These improper claims for PPS discharges were submitted and paid because neither the FIs nor the hospitals involved had a clear understanding of Medicare payment rules applicable to hospital consolidations. Accordingly, we recommend that the Centers for Medicare & Medicaid Services (CMS):

- Issue instructions to its regional offices, FIs, and hospitals that address the applicability of the regulations regarding change of ownership to hospitals which consolidate and form a single Medicare provider;

- Review current claim, cost report, audit, and change of ownership instructions to determine whether revisions or additions are necessary to clearly address proper claim filing and cost treatment when a change of ownership or consolidation occurs;

- Review the change of ownership process to determine whether FIs receive notices of changes of ownership or consolidations in a sufficient and timely manner; and

- Determine whether establishment of a database of hospital change of ownership information would be useful to FIs, CMS regional staff, OIG, and other agencies or organizations with responsibilities for assuring that Medicare payments are correct.

Because we are continuing to identify and review improper claims for PPS discharges after hospital consolidations, we are not making recommendations in this report regarding the recovery of overpayments. We will recommend recovery actions in future reports, as appropriate.

The CMS fully concurred with our recommendations. Specifically, CMS officials stated that they will issue a clarifying Program Memorandum by the end of the year. They also will review the instructions in the regulations and issue clarifications as needed. In addition, CMS advised that it is currently implementing a new data system that will maintain all enrollment and ownership information including changes of ownership.

We find CMS's comments and proposed corrective actions appropriate. We summarized CMS's comments and our response in the RECOMMENDATIONS section of the report. The CMS's entire comments are included as an APPENDIX to our report.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-06-00-00044 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM DISCHARGES IMPROPERLY REPORTED AND PAID AFTER HOSPITAL CONSOLIDATIONS

JANET REHNQUIST
Inspector General

JULY 2002
A-06-00-00044

Memorandum

Date JUL 23 2002

From Janet Rehnquist
Inspector General

Subject Medicare Inpatient Hospital Prospective Payment System Discharges Improperly Reported and Paid After Hospital Consolidations (A-06-00-00044)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

This report provides you with the results of our review of inpatient hospital prospective payment system (PPS) discharges that were improperly reported to and paid by Medicare fiscal intermediaries (FI) after the consolidation of two or more hospitals. The objectives of our review were to (1) determine whether claims were improperly submitted to FIs after two or more PPS hospitals consolidated to form a single Medicare provider and (2) quantify any Medicare overpayments for these improperly submitted claims.

A consolidation of hospitals is considered a change of ownership by Medicare regulations. These regulations require that Medicare payments for services to patients who are discharged after the date of the consolidation be made to the legal owner on the date of discharge. After a consolidation, only the surviving hospital (Medicare provider) would be entitled to the Medicare payments, because it was the legal owner on the date of discharge.

As of June 30, 1998, 15 hospitals that ceased to exist after consolidation with another hospital were paid for 1,118 PPS discharges that should not have been billed to Medicare. To date, as a result of actions taken or planned to address claims and/or cost report issues arising from the 15 consolidations:

- FIs have recovered nearly $300,000 related to two consolidations and have begun recovery actions related to two additional consolidations;
- The Department of Justice (DOJ) has reached settlements totaling nearly $3.2 million related to five consolidations; and
- The Office of Inspector General (OIG) has identified claims overpayments of more than $4.5 million for 6 of the 15 consolidations and will make appropriate referrals to FIs for recovery.

These improper claims for PPS discharges were submitted and paid because neither the FIs nor the hospitals involved had a clear understanding of Medicare payment rules applicable to hospital consolidations. Based on the audit work completed to date, we concluded that FIs:

(1) issued instructions to hospitals that were contrary to applicable Medicare regulations;

(2) did not properly deny the claims or take appropriate actions to prevent the payments and/or recover the overpayments; and

(3) may be reimbursing consolidating hospitals through the cost report when the consolidating hospitals do not submit claims.

Accordingly, we recommend that the Centers for Medicare & Medicaid Services (CMS):

- Issue instructions to its regional offices, FIs, and hospitals that address the applicability of the regulations regarding change of ownership to hospitals which consolidate and form a single Medicare provider;

- Review current claim, cost report, audit, and change of ownership instructions to determine whether revisions or additions are necessary to clearly address proper claim filing and cost treatment when a change of ownership or consolidation occurs;

- Review the change of ownership process to determine whether FIs receive notices of changes of ownership or consolidations in a sufficient and timely manner; and

- Determine whether establishment of a database of hospital change of ownership information would be useful to FIs, CMS regional staff, OIG, and other agencies or organizations with responsibilities for assuring that Medicare payments are correct.

Because we are continuing to identify and review improper claims for PPS discharges after hospital consolidations, we are not making recommendations in this report regarding the recovery of overpayments. We will recommend recovery actions in future reports to FIs, as appropriate.

The CMS fully concurred with our recommendations. Specifically, CMS officials stated that they will issue a clarifying Program Memorandum by the end of the year. They also will review the instructions in the regulations and issue clarifications as needed. In addition, CMS advised that it is currently implementing a new data system that will maintain all enrollment and ownership information including changes of ownership.

We find CMS's comments and proposed corrective actions appropriate. We summarized CMS's comments and our response in the RECOMMENDATIONS section of the report. The CMS's entire comments are included as an APPENDIX to our report.

INTRODUCTION

BACKGROUND

The Medicare PPS for inpatient hospital services provided by acute care general hospitals was authorized in 1983 by Public Law 98-21, and was effective with hospital cost reporting periods beginning on or after October 1, 1983. The PPS established patient discharges as the basis for payment for hospital inpatient services and distinguished between patient transfers and discharges, per 42 CFR 412.4. The hospital that discharged a patient received the full prospectively set payment amount. However, if the patient was discharged as a transfer to another PPS hospital for additional treatment, the transferring hospital received per diem payments for the transfer. The total of the per diem payments for a PPS transfer could not exceed the amount payable had a discharge occurred.

Hospitals that do not accurately report PPS discharges have been a concern of both OIG and CMS for many years. Previous OIG audits concerning patients transferred between PPS hospitals addressed overpayments caused when PPS transfers were incorrectly reported as PPS discharges. Our current review focused on improperly reported PPS discharges after hospital consolidations. The consolidation of two hospitals into a single Medicare provider is considered a change of ownership, as defined by Medicare regulations at 42 CFR 489.18(a)(3). As explained in 42 CFR 412.125, payment for the operating and capital-related costs of inpatient hospital services for each patient is made to the entity that is the legal owner on the date of discharge. As such, the hospital being consolidated should not submit claims for its inpatients at the date of or after the consolidation.

For example, assume that there is a consolidation of Hospital A and Hospital B. Further, assume that Hospital A was the consolidated hospital that lost its identity. Hospital B will continue to exist and bill Medicare under its provider number for services provided to Medicare patients at both locations. Hospital A can no longer bill Medicare and is not allowed to consider its Medicare patients to have been discharged as a transfer to Hospital B. After the consolidation, Hospital B can bill Medicare under its provider number as if all of the Medicare services provided to the Medicare patients at Hospital A had been provided by Hospital B. Because Medicare views the consolidation as a change of ownership, payment may not be made to Hospital A for any PPS claims related to its patients discharged by Hospital B.

The FIs that contract with CMS are responsible for ensuring that payments to hospitals are made in accordance with Medicare regulations. The Medicare overpayments related to consolidations can occur in different forms. In this regard, FIs must have review procedures

in place to alert them to improper PPS transfer claims that should not be paid, including those submitted by a hospital that consolidated with another hospital. In addition, FIs need procedures to ensure that other items, such as capital-related costs, cost outliers, observation services, or medical education costs, which are affected by the consolidation, are properly treated during the cost report settlement processes for both hospitals.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to (1) determine whether claims were improperly submitted to FIs after two or more PPS hospitals consolidated to form a single Medicare provider and (2) quantify any Medicare overpayments for these improperly submitted claims.

To accomplish our objectives, we:

- Reviewed Medicare criteria applicable to hospital changes of ownership;

- Accessed the National Claims History (NCH) file and obtained claims information to identify patterns that could indicate potential hospital consolidations; that is, one PPS hospital reporting its inpatients discharged to the same other PPS hospital;

- Identified from claims posted to NCH between January 1, 1992 and June 30, 1998, the amounts paid by Medicare and the amounts of any inpatient deductibles or coinsurance assessed to Medicare beneficiaries for PPS transfers reported after consolidation;

- Searched the world wide web for news articles, press releases, or other information identifying hospital consolidations;

- Visited selected FIs to review and discuss with FI officials the permanent files, cost reports, and/or audit work papers for those hospitals we identified as possibly being involved in a consolidation;

- Discussed change of ownership criteria with FI officials and the procedures they applied in the audit or reimbursement of hospitals involved in consolidations;

- Began work with internal auditors for a university hospital system to determine the actual consolidation date, the claims that should not have been submitted, and the amount of overpayments received; and

- Assisted DOJ by initiating a referral of consolidations to it, providing DOJ with advice and assistance while it conducted its investigation and negotiation settlement discussions at one of the hospitals it investigated.

The scope of this audit did not include a review of hospital cost reports to identify the impact of items, such as capital-related costs, cost outliers, observation services, or medical education costs, which should affect the amount of the settlements for each hospital involved in consolidations. Where appropriate, we plan to issue separate reports to the FIs with jurisdiction over hospitals involved in the consolidations identified in our audit. In those reports, we will recommend that all applicable cost report issues be addressed by the FIs in making settlements with the hospitals.

Fieldwork was performed at the OIG field office in Baton Rouge, Louisiana, and FIs in Baton Rouge, Louisiana; Jackson, Mississippi; Camarillo, California; Jacksonville, Florida; Des Moines, Iowa; Seattle, Washington; Portland, Oregon; Omaha, Nebraska; and Pittsburgh, Pennsylvania.

Our review was conducted in accordance with generally accepted government auditing standards. In order to meet our objectives, a review of internal controls was not required at either FIs or the hospital we visited.

FINDINGS AND RECOMMENDATIONS

As of June 30, 1998, 15 hospitals that ceased to exist after consolidation with another hospital were paid for 1,118 PPS discharges that should not have been billed to Medicare. To date, as a result of actions taken or planned to address claims and/or cost report issues arising from the 15 consolidations:

- FIs have recovered nearly $300,000 related to two consolidations and have begun recovery actions related to two additional consolidations;

- The DOJ reached settlements totaling nearly $3.2 million related to five consolidations; and

- The OIG has identified an additional six consolidations with claims overpayments of more than $4.5 million that will be referred to FIs for recovery.

These PPS discharges were improperly reported by consolidated PPS hospitals for inpatient services provided to patients who were actually discharged from surviving hospitals. According to Medicare regulations at 42 CFR 412.125, payment for services provided to these patients should only be made to the legal owner; that is, the surviving hospital (Medicare provider) that discharged the patient.

Medicare Regulations

The change of ownership regulations (including consolidations) at 42 CFR 412.125(a) states that:

> "Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments, as provided in section 412.112, and payments for hemophilia clotting factor costs under section 412.115(b), are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller."

The consolidation of two hospitals into a single Medicare provider is a change of ownership under these regulations. As such, the hospital consolidated loses its Medicare provider number and is no longer able to submit claims on its own. This hospital should not submit claims to Medicare for reimbursement of inpatient services provided at the time of consolidation, regardless of a patient's length of stay. The hospital that continues to exist after the consolidation should bill Medicare for these inpatient services, as if the services had been provided by this hospital from the date of admission.

Cause for the Overpayments

Based on our audit work to date, we believe that the overpayments related to consolidations were attributable to the lack of a clear understanding of Medicare regulations by both FIs and hospitals. This lack of understanding is evident in the way both FIs and hospitals have handled claims involving consolidations.

FI Actions

Based on our reviews, we concluded that certain FIs: (1) issued instructions to some hospitals that were contrary to applicable Medicare regulations; (2) did not properly deny the claims or take appropriate actions to prevent the payments and/or recover the overpayments; and (3) may be reimbursing consolidating hospitals through the cost report when they do not submit claims. The following examples illustrate improper actions that FIs have taken:

- An FI serving 6 of the 15 hospitals in our review and 1 outside our review may have issued instructions to its hospitals involved in consolidations. These instructions incorrectly directed hospitals that would cease to exist after the consolidation to report their inpatients transferred to the surviving hospital at the time of the consolidation. We obtained copies of these instructions that were given to two hospitals and we were informed by a hospital representative of a third hospital that also received the instructions. An FI official stated that, in all likelihood, any of its hospitals involved in a change of ownership or consolidation received these instructions.

- Two hospitals within a university health care system (system) were consolidated into one hospital with two locations and the system began filing one Medicare cost report for the consolidated entity. However, the system continued to submit claims under both of the hospitals' Medicare provider numbers. During the next 3 years, 264 inpatients moved between the campuses, as each hospital discharged or transferred patients to the other. System officials said they explained the situation to FI officials, but they did not receive a response that would have helped them avoid improperly submitting the claims related to the 264 inpatients.

Hospital Actions

Hospital officials were also responsible for ensuring that claims submitted by them complied with Medicare regulations. During the 1990's, many hospitals were bought, sold, or involved in some form of merger or consolidation. For the most part, these transactions involved the purchase of one or more hospitals with the acquiring entity merging the consolidating hospital(s) into its ongoing healthcare business. However, a number of these transactions involved the consolidation of two or more hospitals into a single Medicare provider. In these consolidations, only one of the Medicare provider numbers survived for use by the newly created hospital. Some of the consolidations resulted in Medicare overpayments because one of the consolidating hospitals reported its patient discharges as transfers to its consolidation partner. Had hospital officials recognized the applicability of 42 CFR 412.125 to their hospital's consolidation, we believe some of the overpayments would not have occurred.

Overpayments to Hospitals

Medicare overpayments to 6 of the 15 hospitals included in our review occurred as a result of claims improperly submitted by the hospitals that ceased to exist after a consolidation. We will issue subsequent OIG reports that will include the results of any recovery actions or will recommend recovery actions, including cost report settlement issues, that need to be addressed for these six hospitals. Therefore, this report does not include recommendations regarding the recovery of the more than $4.5 million that OIG has identified as a result of the consolidations related to the six hospitals. In addition, this report does not include any recommendations applicable to the remaining nine hospitals where FIs have already begun recovery actions or outside investigative agencies have already reached settlements.

Additional Audit Work

The OIG plans to continue working to identify additional consolidations and related potential overpayments. In addition, we plan to expand our review to include other types of changes of ownership to determine whether, for inpatient stays without corresponding submissions of claims, FIs erroneously included reimbursement in settlements of hospital cost reports.

RECOMMENDATIONS

The CMS needs to take the appropriate steps to ensure that the Medicare regulations applicable to changes of ownership are properly applied. Accordingly, we recommend that CMS:

- Issue instructions to its regional offices, FIs, and hospitals that address the applicability of the regulations regarding change of ownership to hospitals which consolidate and form a single Medicare provider;

- Review current claim, cost report, audit, and change of ownership instructions to determine whether revisions or additions are necessary to clearly address proper claim filing and cost treatment when a change of ownership or consolidation occurs;

- Review the change of ownership process to determine whether FIs receive notices of changes of ownership or consolidations in a sufficient and timely manner; and

- Determine whether establishment of a database of hospital change of ownership information would be useful to FIs, CMS regional staff, OIG, and other agencies or organizations with responsibilities for assuring that Medicare payments are correct.

Because we are continuing to identify and review improper PPS discharges after hospital consolidations, we are not making recommendations in this report regarding the recovery of overpayments. We will recommend recovery actions in future reports, as appropriate.

CMS'S COMMENTS

In their written comments to our draft report, CMS fully agreed with our recommendations. Specifically, CMS officials stated that they will issue a clarifying Program Memorandum by the end of the year. They also will review the instructions in the regulations and issue clarifications as needed. In addition, CMS advised that it is currently implementing a new data system that will maintain all enrollment and ownership information including changes of ownership. The CMS also provided technical comments.

OIG'S RESPONSE

We find CMS's comments and proposed corrective actions appropriate. In addition, with respect to CMS's technical comments, we made changes to the final report as appropriate.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
(formerly Health Care Financing Administration)

DATE: JUN - 3 2002

TO: Janet Rehnquist
Inspector General
Office of Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Inpatient Hospital Prospective Payment System Discharges Improperly Reported and Paid After Hospital Consolidations* (A-06-00-00044)

Thank you for the opportunity to review and comment on the above-referenced draft report which: 1) determined whether claims were improperly submitted to fiscal intermediaries (FIs) after two or more prospective payment system (PPS) hospitals consolidated to form a single Medicare provider; and 2) quantified any Medicare overpayments for these improperly submitted claims.

The OIG recommends that the Centers for Medicare & Medicaid Services (CMS): 1) issue instructions to its regional offices, FIs, and hospitals that address the applicability of the regulations regarding change of ownership to hospitals which consolidate and form a single Medicare provider; and 2) review current claim, cost report, audit, and change of ownership instructions to determine whether revisions or additions are necessary to clearly address proper claim filing and cost treatment when a change of ownership or consolidation occurs.

CMS Response
We concur. We will issue a clarifying Program Memorandum by the end of the year. We will also review the instructions in the regulations and issue clarifications as needed.

The OIG also recommends that CMS: 1) review the change in ownership process to determine whether FIs receive notices of changes of ownership or consolidations in a sufficient and timely manner; and 2) determine whether establishment of a database of hospital change of ownership information would be useful to FIs, CMS regional staff, OIG, and other agencies or organizations with responsibilities for ensuring that Medicare payments are correctly made.

CMS Response

We concur. The CMS is in the final stages of implementing a new data system called Provider Enrollment, Chain, and Ownership System (PECOS) which will be available to CMS and its contractors in mid-June 2002. The PECOS will maintain all enrollment and ownership information including changes in ownership.

We look forward to working with OIG on this and other issues pertinent to Medicare inpatient hospital PPS discharges that are incorrectly reported.

Attachment