DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAY 6 2004

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan
Acting Principal Deputy Inspector General

SUBJECT: Review of the Classification of Missouri Provider Tax Refunds on Hospitals' Medicare Cost Reports (A-07-02-04006)

Attached are two copies of our final report entitled "Review of the Classification of Missouri Provider Tax Refunds on Hospitals' Medicare Cost Reports." This issue came to our attention while we were conducting Medicaid audits relating to the Missouri provider tax program. We pursued this review because Missouri hospitals received more than $100 million in provider tax refunds over a 4-year period.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234, codified at section 1903(w) to the Social Security Act) authorized States to levy broad-based, uniform tax assessments on hospitals.

Because the Missouri provider tax was assessed on all patients, including Medicare beneficiaries, hospitals recorded the tax expenses and refunds on their Medicare cost reports. While hospitals received the majority of their Medicare reimbursement under a prospective payment system, they were paid for outpatient services under a cost reimbursement system during our audit period. Reimbursement under that system was settled through the submission of Medicare cost reports.

Our objective was to determine whether Missouri hospitals properly claimed provider tax refunds on their Medicare cost reports from January 1, 1997 to August 1, 2000. According to 42 CFR § 413.98, refunds of previous expense payments are reductions of the related expense. Furthermore, section 1861(v)(1)(A) of the Social Security Act states that the reasonable cost of any services shall be the cost actually incurred. Additionally, section 2105.7 of the Medicare "Provider Reimbursement Manual" provides that costs incurred by providers for gifts or donations to charitable, civic, educational, medical, or political entities are not allowable.

We found that 15 of the 17 Missouri hospitals that received the largest provider tax refunds from the Missouri Hospital Association (the Association) improperly classified the refunds on at least 1 of their Medicare cost reports. The refunds were redistributed from an Association pool established by Missouri hospitals to mitigate the impact of the provider tax imposed by the State. Although the Missouri Medicaid program did not generate these payments, the hospitals classified the tax refunds as Medicaid revenue, rather than as a reduction of the related expense,

on their Medicare cost reports. We also found that 4 of the 17 hospitals included on their Medicare cost reports unallowable expenses for donations to the Association.

As a result of the improper cost report treatment of the refunds and the unallowable expenses, the hospitals received $8.4 million in excess Medicare reimbursement. These overpayments occurred because the hospitals did not follow Medicare regulations on claiming provider tax refunds. In addition, when settling cost reports, the intermediary inconsistently applied Medicare rules and regulations.

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- instruct the fiscal intermediary to reopen, before the time limit on reopening cost reports expires, the 1998 through 2000 cost reports[1] for the hospitals listed in Appendix A of the attached report and make proper adjustments to classify the tax refunds as offsets to the provider tax expense;

- instruct the fiscal intermediary to recover from the hospitals listed in Appendix A $8,356,888 in Medicare overpayments related to the improper cost report treatment of provider tax refunds;

- instruct the fiscal intermediary to recover from the hospitals listed in Appendix B $16,156 in Medicare overpayments related to unallowable expenses;

- instruct all fiscal intermediaries servicing Missouri hospitals to educate the provider community on the correct methodology for reporting pool refunds and the allowability of costs on Medicare cost reports; and

- instruct all fiscal intermediaries servicing Missouri hospitals to consistently apply Medicare rules and regulations on refunds of expenses when settling Medicare cost reports.

CMS concurred with all of the recommendations.

If you have any questions or comments about this report, please do not hesitate to call me or have your staff call George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at greeb@oig.hhs.gov. Please refer to report number A-07-02-04006 in all correspondence.

Attachment

[1] In September 2002, CMS directed the fiscal intermediary to reopen the 1997 cost reports.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE CLASSIFICATION OF MISSOURI PROVIDER TAX REFUNDS ON HOSPITALS' MEDICARE COST REPORTS

May 2004
A-07-02-04006

EXECUTIVE SUMMARY

OBJECTIVE

Our objective was to determine whether Missouri hospitals properly claimed provider tax refunds on their Medicare cost reports from January 1, 1997 to August 1, 2000. The Missouri Hospital Association (the Association) redistributed the refunds from a pool established by hospitals to mitigate the impact of the State's provider tax.

SUMMARY OF FINDINGS

Our review of the 17 Missouri hospitals that received the largest provider tax refunds found that some hospitals improperly classified provider tax refunds and included unallowable expenses on their Medicare cost reports:

- Fifteen of the 17 hospitals recorded the refunds as Medicaid revenue, rather than as a reduction of the tax expense, on at least 1 of their Medicare cost reports. However, the Missouri Medicaid program did not generate these payments. According to 42 CFR § 413.98, refunds of previous expense payments are reductions of the related expense. Furthermore, section 1861(v)(1)(A) of the Social Security Act states that the reasonable cost of any services shall be the cost actually incurred.

- Four of the 17 hospitals included on their Medicare cost reports unallowable expenses. These unallowable expenses were payments to the Association for a scholarship fund and a poison control center. Section 2105.7 of the Medicare "Provider Reimbursement Manual" provides that costs incurred by providers for gifts or donations to charitable, civic, educational, medical, or political entities are not allowable.

As a result of the improper cost report treatment of the refunds and the unallowable expenses, the hospitals overstated their expenses and received $8.4 million in excess Medicare reimbursement. These improper payments occurred because the hospitals did not follow Medicare regulations on claiming provider tax refunds. In addition, when settling cost reports, the fiscal intermediary inconsistently applied Medicare rules and regulations.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- instruct the fiscal intermediary to reopen, before the time limit on reopening cost reports expires, the 1998 through 2000 cost reports[1] for the hospitals listed in

[1] In September 2002, CMS directed the fiscal intermediary to reopen the 1997 cost reports.

Appendix A and make proper adjustments to classify the tax refunds as offsets to the provider tax expense;

- instruct the fiscal intermediary to recover from the hospitals listed in Appendix A $8,356,888 in Medicare overpayments related to the improper cost report treatment of provider tax refunds;

- instruct the fiscal intermediary to recover from the hospitals listed in Appendix B $16,156 in Medicare overpayments related to unallowable expenses;

- instruct all fiscal intermediaries servicing Missouri hospitals to educate the provider community on the correct methodology for reporting pool refunds and the allowability of costs on Medicare cost reports; and

- instruct all fiscal intermediaries servicing Missouri hospitals to consistently apply Medicare rules and regulations on refunds of expenses when settling Medicare cost reports.

CMS concurred with all of the recommendations. CMS's response is included in its entirety in Appendix C.

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INTRODUCTION

BACKGROUND

The Medicare and Medicaid Programs

The Medicare program, enacted in 1965, is the Nation's largest health insurance program, covering nearly 40 million Americans. Medicare Part A helps pay for inpatient hospital and skilled nursing facility services for individuals aged 65 and older, those who are disabled, and those with permanent kidney failure. Hospitals settle Medicare reimbursement for the services rendered during a fiscal year by submitting Medicare cost reports.

Also enacted in 1965, Medicaid is a combined Federal-State entitlement program which provides health and long-term care for certain individuals and families with low incomes and resources. Within a broad legal framework, each State designs and administers its own Medicaid program, including determining how much to pay hospitals for each service. Each State operates under a plan approved by CMS for compliance with Federal laws and regulations. The Federal Government established a financing formula to calculate the Federal share of the medical assistance expenditures under each State's Medicaid program.

In Missouri, the Department of Social Services is responsible for administering Medicaid.

Missouri Hospital Provider Tax Program

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234, codified at section 1903(w) to the Social Security Act) authorized States to levy broad-based, uniform tax assessments on hospitals. On October 1, 1992, Missouri instituted the hospital provider tax, also known as the Federal Reimbursement Allowance program. By using the taxes collected to pay its required matching share of Medicaid expenditures, the State was able to capture additional Federal funding. Missouri hospitals arranged for the Association to receive all Medicaid reimbursement.

To mitigate the impact of the provider tax, the Association created a redistribution pool arrangement on behalf of the hospitals. In the absence of this redistribution arrangement, the provider tax would have had a negative financial impact on certain hospitals while creating a financial gain for others.[2] Under the redistribution arrangement, hospitals receiving additional Medicaid reimbursement that exceeded their provider tax allowed the Association to redistribute a portion of their funds to hospitals that were negatively affected by the tax.

[2] Missouri increased Medicaid reimbursement simultaneously with the assessment of the provider tax in part to reduce the impact of the tax. To ensure that the tax was uniform, the State levied the tax on all patients (including Medicare, private insurance, and Medicaid). Hospitals with a high percentage of Medicaid patients received increased Medicaid reimbursement that exceeded the total provider tax assessment for all of their patients. Therefore, in the absence of the redistribution agreement, these hospitals would have benefited financially from the provider tax.

For 10 years, CMS challenged the legality of the tax under the "hold harmless" provisions of the 1991 statute and implementing regulations at 42 CFR § 433.68(f). Those provisions specify that health-care-related taxes are permissible if they do not hold providers harmless for their tax costs. CMS asserted that the Missouri provider tax was impermissible because hospitals were held harmless from the tax as a result of the redistribution arrangement. Therefore, according to CMS, the provider tax revenue would not be eligible for Federal Medicaid matching funds. The State vigorously rebutted CMS's assertions, and CMS and the State ultimately arrived at a compromise for Medicaid purposes in December 2002. As part of the agreement, the State agreed to change its financing formula.

Because the State assessed the tax on all patients, including Medicare beneficiaries, hospitals recorded the tax expenses and refunds on their Medicare cost reports.[3] While hospitals received the majority of their Medicare reimbursement under a prospective payment system, they were paid for outpatient services under a cost reimbursement system during our audit period. Reimbursement under that system was settled through the submission of Medicare cost reports.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Missouri hospitals properly claimed provider tax refunds on their Medicare cost reports from January 1, 1997 to August 1, 2000.

Scope

Our review was limited to the 17 hospitals that received the largest pool refunds from the Association during our audit period. We did not assess the propriety of the provider tax as it pertained to the Medicaid program. We also did not assess the internal controls of the State, the hospitals, or the Association.

Methodology

To understand the provider tax and the redistribution pool, we reviewed documents provided by CMS and fiscal intermediary officials. In addition, we interviewed officials of CMS, the State, the Association, and the 17 hospitals.

For each of the 17 hospitals, we reviewed Medicare cost reports; State tax assessment letters; State Medicaid reimbursement advice summaries; the Association remittance

[3] Hospitals are prohibited from claiming the voluntary transfer payments to the Association pool as a tax expense on their Medicare cost reports. Section 2122.1 of the Medicare "Provider Reimbursement Manual" states that taxes assessed against the provider, in accordance with the levying enactments of the States and lower levels of government and for which the provider is liable for payments, are allowable costs. However, transfers to the pool were not mandated under Missouri's taxing authority. As a result, the hospitals are not allowed to claim these transfers as tax expenses.

advices and notices of accounts payable; signed agreements between the hospital and the Association; general ledger account balances for specific Medicare cost report items, such as the provider taxes paid and the pool refund received; and checks from the hospital to the State for provider taxes paid. We determined whether the tax was assessed, whether the tax was collected, the amount of the pool refund, how each hospital recorded the tax and pool refund in its books and records, and how each hospital claimed the tax and pool refund on its Medicare cost report.

For each cost report period reviewed, we asked the fiscal intermediary to calculate the overpayment based on the amount of the pool refund the hospital received that was not properly offset against the provider tax paid. The intermediary responded with the overpayment for each hospital.

We performed our review at the Department of Social Services, Division of Medical Services in Jefferson City, MO, and at the 17 hospitals. We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Our review of Medicare cost reports for 1997 through 2000 found that Missouri hospitals did not always claim provider tax refunds and expenses in accordance with Medicare rules and regulations. Specifically, 15 of 17 hospitals classified the refunds as Medicaid revenue, rather than as a reduction of the tax expense, on at least 1 of their cost reports. In addition, 4 of 17 hospitals included on their cost reports unallowable expenses for donations to a scholarship fund and a poison control center.

As a result of the improper cost report treatment of the refunds and the unallowable expenses, the hospitals received $8.4 million in excess Medicare reimbursement. These overpayments occurred because the hospitals did not follow Medicare regulations on claiming provider tax refunds. In addition, the intermediary did not consistently apply Medicare regulations.

POOL REFUNDS IMPROPERLY CLASSIFIED

Under 42 CFR § 413.98, refunds of previous expense payments are reductions of the related expense. Furthermore, section 1861(v)(1)(A) of the Social Security Act states that the reasonable cost of any services shall be the cost actually incurred.

Fifteen hospitals that received pool refunds from the Association recorded them incorrectly as Medicaid revenue, instead of offsetting the provider tax expense, on at least one of their Medicare cost reports. These pool refunds represented transfers between hospitals and resulted in a refund of a portion of the provider tax to the hospitals negatively affected by the tax. State officials acknowledged that the State Medicaid program did not generate these pool refunds. Moreover, the State provided each hospital with an annual Internal Revenue Service (IRS) Form 1099 that summarized total Medicaid payments. The pool redistribution amounts were not included on the

Form 1099. Accordingly, we concluded that the pool redistributions did not represent Medicaid revenue to the hospitals but were, instead, refunds of the provider tax expense.

As a result of the improper classification of the provider tax refunds, Medicare overpaid the 15 hospitals $8,356,888. Specifically, 13 hospitals incorrectly classified the tax refunds on all of the cost reports we reviewed. They included $82,579,181 in improper expenses on their cost reports, resulting in $7,396,838 in excess Medicare reimbursement. Two other hospitals incorrectly classified the tax refunds on some cost reports and correctly classified the refunds as offsets to the provider tax expense on at least one other cost report. However, the fiscal intermediary incorrectly reversed the offsets on one hospital's cost reports. These two hospitals included $19,833,513 in improper expenses on their cost reports, resulting in $960,050 in excess Medicare reimbursement. (See Appendix A.)

The overpayments occurred because the hospitals did not follow Medicare regulations on claiming provider tax refunds.

To protect the Medicare trust fund, in September 2002, a CMS Region VII official directed the fiscal intermediary to notify Missouri hospitals that fiscal year 1997 Medicare cost reports were being reopened in preparation for making audit adjustments to offset the pool refunds. CMS took this step as a result of the interim findings of this review.

UNALLOWABLE COSTS CLAIMED

According to the Medicare "Provider Reimbursement Manual," section 2105.7, the "costs incurred by providers for gifts or donations to charitable, civic, educational, medical, or political entities are not allowable." However, 4 of the 17 hospitals included on their Medicare cost reports payments to the Association for a scholarship fund and a poison control center. The fiscal intermediary disallowed these expenses at some hospitals; however, the intermediary did not identify these unallowable costs at the four hospitals. The hospitals claimed $210,019 in unallowable Medicare costs, resulting in $16,156 in excess Medicare reimbursement. (See Appendix B.)

RECOMMENDATIONS

We recommend that CMS:

- instruct the fiscal intermediary to reopen, before the time limit on reopening cost reports expires, the 1998 through 2000 cost reports for the hospitals listed in Appendix A and make proper adjustments to classify the tax refunds as offsets to the provider tax expense;

- instruct the fiscal intermediary to recover from the hospitals listed in Appendix A $8,356,888 in Medicare overpayments related to the improper cost report treatment of provider tax refunds;

- instruct the fiscal intermediary to recover from the hospitals listed in Appendix B $16,156 in Medicare overpayments related to unallowable expenses;

- instruct all fiscal intermediaries servicing Missouri hospitals to educate the provider community on the correct methodology for reporting pool refunds and the allowability of costs on Medicare cost reports; and

- instruct all fiscal intermediaries servicing Missouri hospitals to consistently apply Medicare rules and regulations on refunds of expenses when settling Medicare cost reports.

CMS COMMENTS

CMS concurred with all of the recommendations. Specifically, CMS will coordinate with Office of Inspector General staff to obtain the provider numbers for the hospitals listed in Appendices A and B and will instruct the fiscal intermediaries to issue reopening letters for the cost reports, take appropriate recovery efforts, educate the provider community, and consistently apply Medicare rules and regulations when settling Medicare cost reports. CMS's response is included in its entirety in Appendix C.

OTHER MATTER

In an informal response to our findings, some hospital officials stated that if the refunds could not be claimed as Medicaid revenue, they should be claimed as charitable donations. In addition, in a 2002 letter to the CMS Administrator, an Association official said that several large certified public accounting firms had advised the hospitals in the mid-1990s to treat the pool redistributions as charitable contributions received. However, none of the hospitals recorded the transactions as charitable contributions.

We disagree that the tax refunds are charitable contributions. The transactions did not meet the charitable contribution standards under generally accepted accounting principles or IRS regulations for Federal tax purposes. Moreover, section 607 of the Medicare "Provider Reimbursement Manual" does not allow affiliated hospitals to transfer funds to each other and claim them as charitable contributions.

According to generally accepted accounting principles, a contribution is "an unconditional transfer of cash or other assets to an entity or a settlement or cancellation of its liabilities in a voluntary nonreciprocal transfer by another entity acting other than as an owner."[4] (Emphasis added.) According to IRS Publication 526, a charitable contribution "is a donation or gift to, or for the use of, a qualified organization. It is voluntary and is made without getting or expecting to get anything of equal value."

While the redistribution of funds was voluntary, it was conditional. Hospitals voluntarily allowed the Association to redistribute the funds based on a formula prescribed in the agreement between the Association and the hospitals. Using this formula, hospitals

[4] Federal Accounting Standards Board Statement of Standards 116.

transferred funds to the pool only because by doing so, they received increased funds under the State's Federal Reimbursement Allowance program.[5] The hospitals that received pool refund payments supported the State's Federal Reimbursement Allowance program and the subsequent Nursing Facility Reimbursement Allowance program because they were promised pool refunds to mitigate provider taxes.[6] Therefore, the transfers did not meet the definition of charitable donations under generally accepted accounting principles because the transfers were not unconditional.

Even if the pool redistributions were unconditional and qualified as contributions under the accounting principles, chain hospitals would be required to make an adjustment for the portion of pool contributions that originated from affiliated entities. Funds transferred between hospitals with common ownership may not be classified as gifts or donations according to Medicare rules. Specifically, section 607 of the Medicare "Provider Reimbursement Manual" states: "Whether or not they are characterized as a 'grant' or a 'gift,' funds transferred to a provider from another component of the same organizational entity . . . are not considered a grant or gift for Medicare reimbursement purposes but rather an internal transaction amounting only to self-financing . . . ." None of the hospitals made such adjustments for affiliated entities.

[5] Missouri Revised Statutes, chapter 208, section 473 and chapter 198, section 431 stipulate that the provider tax would be collected and the additional Medicaid payments would be made only as long as the revenues generated by the provider tax programs are eligible for Federal funding and payments are made.

[6] After the hospital provider tax was adopted, a State task force recommended adopting a Nursing Facility Provider tax along with increased Medicaid reimbursement modeled after the hospital Federal Reimbursement Allowance program. The legislation was delayed until the nursing home associations could create a pool arrangement to mitigate the tax. One of the associations lobbied for the delay because it recognized that the facilities receiving a positive financial impact from the provider tax would not participate in the pool if the legislation did not include a pool arrangement to ensure that no facility was negatively affected. Once the pool arrangement was in place, the association's objection was lifted and the State legislature passed the bill.

APPENDICES

POOL REFUNDS NOT DEDUCTED FROM THE PROVIDER TAX EXPENSE

Hospital	Cost Report Fiscal Year End	Pool Refund Reduction[7]	Medicare Overpayment[8]
Thirteen hospitals incorrectly claimed the pool refund for all years reviewed.			
1. St. Anthony's Medical Center	6/30/1998	$2,317,480.98	$137,979.00
	6/30/1999	2,149,890.00	108,769.00
	6/30/2000	2,702,341.72	94,041.49
2. Missouri Baptist	12/31/1998	5,345,258.78	394,864.00
	12/31/1999	6,137,869.00	398,156.00
3. St. Luke's Hospital	6/30/1998	6,525,118.02	428,120.00
	6/30/1999	6,680,798.00	341,609.00
	6/30/2000	6,233,798.49	427,527.00
4. North Kansas City	6/30/1999	2,267,412.00	183,139.00
	6/30/2000	2,590,636.00	130,993.00
5. Kindred	4/30/1998	672,711.44	348,195.44
	8/31/1998	241,396.84	115,580.81
	8/31/1999	1,037,619.00	563,187.00
	8/31/2000	1,676,534.00	796,018.34
6. Heartland Regional Medical Center	6/30/1997	20,480.00	2,548.00
	6/30/1998	1,693,840.72	174,524.00
	6/30/1999	620,512.00	46,135.00
7. Capital Regional Medical Center	6/30/1998	1,145,684.00	157,760.69
	6/30/1999	1,312,412.00	142,002.98
	6/30/2000	1,378,553.00	138,268.87
8. Boone Hospital Center	12/31/1997	2,253,977.00	217,689.00
	12/31/1998	2,708,999.00	173,664.00
	12/31/1999	2,502,255.00	137,972.00
9. Columbia Regional Hospital	6/30/1998	965,317.78	157,940.00
	9/30/1999	1,143,753.68	157,756.00
10. Research Medical Center	12/31/1997	2,034,354.16	163,844.00
	12/31/1998	2,841,414.18	189,952.00
	12/31/1999	3,571,609.00	230,040.00
11. Baptist Medical Center	12/31/1998	4,160,099.26	302,108.00
	12/31/1999	3,724,626.00	242,473.15

[7] The pool refund reduction is the total provider tax refunds received by the hospital that were not offset against the tax on the Medicare cost report.

[8] At our request, the fiscal intermediary calculated the Medicare overpayment. The calculation was based on the percentage of the pool refund reduction allocated to Medicare on the Medicare cost report. This primarily represented outpatient hospital services that were paid under cost reimbursement. As of August 2000, CMS converted the hospital outpatient payment system from cost reimbursement to prospective payment.

Hospital	Cost Report Fiscal Year End	Pool Refund Reduction	Medicare Overpayment
12. Lee's Summit Hospital	12/31/1997	706,495.23	54,562.00
	12/31/1998	718,587.06	41,757.00
	12/31/1999	628,996.00	35,914.00
13. Medical Center of Independence	12/31/1997	1,041,131.33	109,419.00
	12/31/1999	827,220.00	52,329.00
Subtotal		$82,579,180.67	$7,396,837.77
Two hospitals offset the refunds on at least one cost report.[9]			
14. Independence Regional Health Center	12/31/1997	$168,855.88	$27,878.11
	12/31/1999	1,479,296.00	135,232.00
15. St. John's Mercy Medical Center	6/30/1998	5,898,749.00	301,091.00
	6/30/1999	6,147,506.00	256,101.00
	6/30/2000	6,139,106.00	239,748.00
Subtotal		$19,833,512.88	$960,050.11
Total		**$102,412,693.55**	**$8,356,887.87**

[9] One of the hospitals deducted the refund for the second cost report period but made an error for the first cost report period. For the third cost report period, the hospital's new owners did not deduct the refund. Another hospital offset the refunds for two cost report periods. However, the fiscal intermediary ultimately reversed these offsets. In the third cost report period, the hospital did not offset the refunds on the advice of fiscal intermediary officials.

APPENDIX B

UNALLOWABLE COSTS INCLUDED ON COST REPORTS

Hospital	Cost Report Fiscal Year	Unallowable Costs	Medicare Overpayment
Capital Regional Medical Center	1998	$1,063.38	$146.43
	1999	14,971.00	1,619.86
	2000	6,931.00	695.18
Boone Hospital Center	1997	11,779.68	1,137.92
	1998	23,578.66	1,511.39
	1999	24,026.00	1,323.83
St. John's Mercy Medical Center	1998	16,706.76	852.04
	1999	16,292.00	679.38
	2000	17,148.00	670.49
North Kansas City	1998	27,481.44	3,960.08
	1999	34,020.00	2,748.82
	2000	16,021.00	810.66
Total		**$210,018.92**	**$16,156.08**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 25 2004

RECEIVED
2004 MAR 29 PM 3:37
OFFICE OF INSPECTOR GENERAL

TO: Dara Corrigan
Acting Principal Deputy Inspector General

FROM: Dennis G. Smith
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Review of the Classification of Missouri Provider Tax Refunds on Hospitals' Medicare Cost Reports* (A-07-02-04006)

Thank you for the opportunity to review and comment on the above-referenced draft report. The OIG performed a review of the classification of Missouri provider tax refunds on Missouri hospital cost reports to determine whether providers had properly reported those refunds on submitted cost reports. The OIG found that in numerous instances, providers had improperly classified refunds of the provider tax as revenue and not as an expense offset, which is the appropriate classification. The OIG also noted that unallowable expenses related to gifts or donations to the state hospital association were not properly offset on several reports.

The Centers for Medicare & Medicaid Services' (CMS) appreciates the effort that went into this report and the opportunity to review and comment on the issues it raises. Our responses to the recommendations are discussed below.

OIG Recommendation
The CMS should instruct the fiscal intermediary (FI) to reopen before the time limit on reopening cost reports expire, the 1998 through 2000 cost reports for the hospitals listed in Appendix A and make proper adjustments to classify the tax refunds as offsets to the provider tax expense.

CMS Response
We concur. The CMS will coordinate with OIG staff to obtain the provider numbers for the hospitals listed in Appendix A and B and will then instruct the appropriate FI to issue reopening letters for those cost reports that are within the 3-year reopening timeframe.

OIG Recommendation
The CMS should instruct the FI to recover from the hospitals listed in Appendix A $8,356,888 in Medicare overpayments related to the improper cost report treatment of provider tax refunds.

CMS Response
We concur and will instruct the FIs to take appropriate recovery efforts.

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OIG Recommendation
The CMS should instruct the FI to recover from the hospitals listed in Appendix B $16,156 in Medicare overpayments related to unallowable expenses.

CMS Response
We concur and will instruct the FIs to take appropriate recovery efforts.

OIG Recommendation
The CMS should instruct all FIs servicing Missouri hospitals to educate the provider community on the correct methodology for reporting pool refunds and the allowability of costs on Medicare cost reports.

CMS Response
We concur and will notify the FI that it should communicate to its providers the proper reporting methodology of the Missouri provider tax refunds.

OIG Recommendation
The CMS should instruct all FIs servicing Missouri hospitals to consistently apply Medicare rules and regulations on refunds of expenses when settling Medicare cost reports.

CMS Response
We concur and will direct the FI to train its audit staff on this issue.