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

REGION V
OFFICE OF
INSPECTOR GENERAL

September 23, 2009

Report Number: A-05-07-00083

Mr. Chuck Nelson
President and Chief Executive Officer
Aspirus Keweenaw Hospital
205 Osceola Street
Laurium, Michigan 49913

Dear Mr. Nelson:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Select Medicare Conditions of Participation and Costs Claimed at Aspirus Keweenaw Hospital from August 1, 2004, Through September 30, 2006." 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.

Section 8L of the Inspector General Act, U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Jaime Saucedo, Audit Manager, at (312) 353-8693 or through email at jaime.saucedo@oig.hhs.gov. Please refer to report number A-05-07-00083 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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 SELECT MEDICARE CONDITIONS OF PARTICIPATION AND COSTS CLAIMED AT ASPIRUS KEWEENAW HOSPITAL FROM AUGUST 1, 2004, THROUGH SEPTEMBER 30, 2006

Daniel R. Levinson
Inspector General

September 2009
A-05-07-00083

Office of Inspector General

http://oig.hhs.gov

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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

Section 4201 of the Balanced Budget Act of 1997, P.L. No. 105-33, Social Security Act, § 1820, 42 U.S.C. § 1395i-4, authorized States to establish Medicare Rural Hospital Flexibility Programs and to designate certain facilities as Critical Access Hospitals (CAH). CAHs must meet certain Medicare Conditions of Participation (CoP) (42 CFR §§ pt. 485, subpart F) and guidelines established by the Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program.

Section 405(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P.L. No. 108-173, Social Security Act, § 1820(c)(2)(B)(iii), 42 U.S.C. § 1395i-4(c)(2)(B)(iii), allowed CAHs to have up to 25 inpatient beds that could be used for acute care or swing-bed services, with CMS approval. The CMS State Operations Manual (SOM), Pub. No. 100-7, Appendix W, section C-0211, effective May 21, 2004**,** references requirements at 42 CFR § 485.620(a) and, for the audit period (April 1, 2004, through September 30, 2006), stated that outpatient observation patients should not be commingled with inpatients. Section 405(a) of the MMA, Social Security Act §§ 1814(l), 1834(g)(1) and 1883(a)(3), 42 U.S.C. §§ 1395f(l), 1395m(g)(1) and 1395tt(a)(3), allowed CAHs to receive Medicare reimbursement totaling 101 percent of allowable, allocable, and reasonable costs for payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

OBJECTIVES

Our objectives were to determine whether the hospital complied with select Medicare CoP and reported costs that were allowable, allocable, and reasonable on its 2004, 2005, and 2006 Medicare cost reports in accordance with Federal requirements.

SUMMARY OF FINDINGS

The hospital was noncompliant with Medicare CoP during the audit period because it commingled inpatients with observation patients. A review of daily census reports indicated 253 instances during the audit period when inpatient beneficiaries were commingled with observation patients in the same room on the same day. The hospital commingled inpatient and observation patients because staff believed that existing Federal requirements conflicted with informal CMS guidance that was provided indirectly to the hospital. However, hospital daily census reports indicated that inpatient and observation patients were commingled before the hospital indirectly received the informal guidance. In addition, the hospital reported unallowable costs totaling $294,479 on its 2004, 2005, and 2006 Medicare cost reports.

RECOMMENDATIONS

We recommend that the hospital:

- ensure that it is compliant with the Medicare CoP by following CMS guidance related to commingling of inpatient with observation patients;

- revise and resubmit its Medicare cost reports for 2004, 2005, and 2006, to properly reflect the exclusion of the $294,479 in unallowable costs; and

- ensure that it only reports allowable costs on future Medicare cost reports.

HOSPITAL COMMENTS

In written comments on our draft report, the hospital said that it generally acknowledged and accepted the report except for the finding that the hospital reported unallowable costs totaling $199,270. The hospital said that the costs were allowable because they were reasonable, necessary, and proper costs in developing and maintaining the operation of its patient care facilities and activities.

The hospital's comments are included as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the hospital's comments, we maintain that our findings and recommendations are valid. Federal regulations (42 CFR § 413.9) provide that payments to a hospital must be based on the reasonable cost of Medicare services and related to the care of beneficiaries. The costs were not necessary and proper costs related to patient care as required by the Federal regulations.

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INTRODUCTION

BACKGROUND

Critical Access Hospitals

Section 4201 of the Balanced Budget Act of 1997, P.L. No. 105-33, Social Security Act, § 1820, 42 U.S.C. § 1395i-4, authorized States to establish Medicare Rural Hospital Flexibility Programs and to designate certain facilities as Critical Access Hospitals (CAH). CAHs must meet certain Medicare Conditions of Participation (CoP) (42 CFR §§ pt. 485, subpart F) and guidelines established by the Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program.

Section 405(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P.L. No. 108-173, Social Security Act, § 1820(c)(2)(B)(iii), 42 U.S.C. § 1395i-4(c)(2)(B)(iii), allowed CAHs to have up to 25 inpatient beds that could be used for acute care or swing-bed services, with CMS approval.[1] The CMS State Operations Manual (SOM), Pub. No. 100-7, Appendix W, section C-0211, effective May 21, 2004**,** references requirements at 42 CFR § 485.620(a) and, for the audit period (April 1, 2004, through September 30, 2006), stated that outpatient observation patients should not be commingled with inpatients. Section 405(a) of the MMA, Social Security Act §§ 1814(l), 1834(g)(1) and 1883(a)(3), 42 U.S.C. §§ 1395f(l), 1395m(g)(1) and 1395tt(a)(3), allowed CAHs to receive Medicare reimbursement totaling 101 percent of allowable, allocable, and reasonable costs for payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

Aspirus Keweenaw Hospital

Aspirus Keweenaw Hospital (the hospital), located in Larium, Michigan, is a not-for-profit corporation. On August 1, 2004, the State of Michigan designated the hospital a necessary provider and CAH under 42 CFR § 485.606. The hospital provides inpatient, outpatient, emergency, medical and physician clinic services. The hospital received Federal reimbursement totaling $16 million for costs reported on its 2004, 2005, and 2006 Medicare cost reports.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the hospital complied with select Medicare CoP and reported costs that were allowable, allocable, and reasonable on its 2004, 2005, and 2006 Medicare cost reports in accordance with Federal requirements.

[1] A swing-bed can be used interchangeably for either inpatient care or skilled nursing care. A patient "swings" or transitions from receiving inpatient services to receiving skilled nursing services.

Scope

We reviewed the hospital's compliance with select Medicare CoP and costs reported for the period August 1, 2004, through September 30, 2006.[2] We also reviewed the hospital's daily census reports for the same period.[3]

We limited our internal control review to obtaining an overall understanding of the hospital's policies and procedures for complying with the Medicare CoP and reporting costs on its Medicare cost reports.

We performed our fieldwork at the hospital located in Larium, Michigan.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal CAH requirements;
- reviewed the hospital's policies and procedures related to compliance with select Medicare CoP and cost reporting requirements;
- reviewed daily census reports to determine whether the hospital complied with CMS guidance related to commingling of inpatient and observation patients;
- analyzed the hospital's financial statements and Medicare cost reports for the audit period and determined whether reported costs were allowable, allocable, and reasonable; and
- observed the number of inpatient beds available for use on November 27, 2007.

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 objectives.

FINDINGS AND RECOMMENDATIONS

The hospital was noncompliant with Medicare CoP during the audit period because it commingled inpatients with observation patients. A review of daily census reports indicated 253 instances during the audit period when inpatient beneficiaries were commingled with observation

[2]The hospital's Medicare cost reporting period is October 1 through September 30. The hospital became a CAH in August 1, 2004. We reviewed three cost reporting periods: the 2-month period starting August 1, 2004, through September 30, 2004 (after CAH conversion); and the two 12-month periods ending September 30, 2005 and 2006.

[3]Daily census reports provide patient information such as name, the level of care being provided, location within the hospital, and admission information.

patients in the same room on the same day. The hospital commingled inpatient and observation patients because staff believed that existing Federal requirements conflicted with informal CMS guidance that was provided indirectly to the hospital. However, hospital daily census reports indicated that inpatient and observation patients were commingled before the hospital indirectly received the informal guidance. In addition, the hospital reported unallowable costs totaling $294,479 on its 2004, 2005, and 2006 Medicare cost reports.

COMMINGLING INPATIENT AND OBSERVATION PATIENTS

The hospital was noncompliant with a Medicare CoP because it commingled inpatients with observation patients in the same room and on the same day.

Federal Requirements

Federal regulations at 42 CFR § 485.620(a) state that CAHs may maintain "no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services." The CMS State Operations Manual (SOM), Pub. No. 100-7, Appendix W, Tag C-0211, effective May 21, 2004**,** interpreted that requirement and stated, "Outpatient observation patients should not be commingled with inpatients." In April 2008, CMS updated the SOM and excluded this language from section C-0211, but did not indicate whether commingling patients was allowable.

Commingling Patients

Contrary to the SOM in effect during the audit period, the hospital commingled inpatient and observation patients on 253 instances. Hospital daily census reports showed that during our audit period, the hospital provided services to inpatient and observation patients in the same room on the same day on 253 occasions.

The hospital commingled inpatient with observation patients because staff believed that existing Federal requirements conflicted with informal CMS guidance that was provided indirectly to the hospital. The hospital stated it indirectly received informal guidance from CMS on March 15, 2005, that indicated that CMS did not intend to not allow commingling and that the SOM would be updated to remove such language.[4] When CMS updated the SOM in April 2008, CMS excluded language prohibiting commingling patients. However, neither the SOM nor the accompanying transmittal letter stated or implied that commingling patients was allowable. CMS issued no clarification or guidance regarding the removal of language prohibiting commingling patients**.** Moreover, it was improper to rely on third-hand, informal guidance.

[4]Through email, the CMS Denver Regional Office communicated to the Colorado Rural Health Center that the commingling language was not intended to be included in the SOM. The informal guidance was shared with the Department of Health and Human Services' Health Resources & Services Administration Agency, which in turn shared the guidance with the hospital's rural health liaison group at Michigan State University. The hospital received the informal guidance from the liaison group through email on March 15, 2005.

Our review of hospital daily census reports indicated that inpatient and observation patients were commingled before the hospital indirectly received the informal guidance as indicated in the following table.

Table 1: Commingling Patients	
Time Period	**Instances of Commingling Patients**
August 1, 2004, through March 14, 2005	105
March 15, 2005, through September 30, 2006	148
Total	253

Commingling patients could affect the level of care provided to a patient, and, if wrongly identified as an observation patient, a Medicare beneficiary could be required to make co-insurance payments not required under inpatient status. Therefore, it is important that a hospital makes a clear distinction in determining the level of care a patient requires in deciding whether a beneficiary should be admitted or placed under observation. Because the hospital commingled patients, it was noncompliant with the related CoP specified at 42 CFR § 485.620(a).

UNALLOWABLE COSTS

The hospital reported unallowable costs totaling $294,479 related to severance pay ($199,270), donations ($89,052), and lobbying ($6,157) on its 2004, 2005, and 2006 Medicare cost reports.

Severance Pay

Federal regulations (42 CFR § 413.9) and the CMS Provider Reimbursement Manual, chapter 21, sections 2102.1 and 2102.2, provide that payments to a hospital must be based on the reasonable cost of Medicare services and related to the care of beneficiaries. Necessary and proper costs are costs that "are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities" and "are usually costs that are common and accepted occurrences in the field of the provider's activity." 42 CFR § 413.9(b)(2).

The hospital reported unallowable costs totaling $199,270 for severance payments and costs related to the resignation of its chief executive officer (CEO) on its 2004 and 2005 Medicare cost reports as detailed in Table 2.

Table 2: CEO's Severance Pay and Related Costs			
	FY 2004	FY 2005	Total
Severance pay	$16,334	$166,509	$182,843
Legal fees	16,427		16,427
Total Costs	**$32,761**	**$166,509**	**$199,270**

The Employment Agreement between the CEO and the hospital did not require severance payments set forth in the Severance Agreement. Under the Employment Agreement, the CEO was to be employed full-time for a period of nine years as the hospital's President and CEO and on an "as needed" basis for a period of two years upon completion of his full-time employment.

Pursuant to the Employment Agreement, in the event of termination of the Agreement and the CEO's employment "for any reason" during the initial nine-year term, the CEO was only entitled to receive "compensation or other benefits to which [he] was entitled for services performed through the last active date of employment under this Agreement." The CEO was not entitled to any post-employment compensation or benefits because the Employment Agreement was terminated by mutual agreement upon the CEO's resignation. Moreover, the hospital's written or otherwise established severance policy did not require the severance payment. The hospital had no legal obligation to make severance payments nor an established personnel policy to grant severance pay. Consequently, severance payments of $182,843 and related legal fees of $16,427 were not necessary and proper costs related to patient care as required by 42 CFR § 413.9.

Donations

The CMS Provider Reimbursement Manual, chapter 21, section 2105.7, "Costs of Gifts or Donations," states "costs incurred by providers for gifts or donations to charitable, civic, educational, medical or political entities are not allowable."

The hospital reported unallowable costs totaling $89,052 related to contributions and donations to trade associations, charities, or civic entities on its 2004, 2005, and 2006 Medicare cost reports as detailed in Table 3.

Table 3: Unallowable Donations				
	FY 2004	FY 2005	FY 2006	Total
Donations	**$13,242**	**$31,749**	**$44,061**	**$89,052**

Pursuant to CMS requirements, these costs are unallowable.

Lobbying

The CMS Provider Reimbursement Manual, chapter 21, section 2139, "Political and Lobbying Activities," states, "Provider political and lobbying activities are not related to the care of patients. Therefore, costs incurred for such activities are unallowable." Furthermore, section 2139.3, "Organization Dues Related to Lobbying and Political Activities," states, "Trade or other organizations and associations often engage in lobbying and political activities. Therefore, . . . the portion of an organization's dues or other payments related to these activities, . . . is an unallowable cost."

The hospital reported unallowable costs totaling $6,157 related to lobbying activities on its 2004, 2005, and 2006 Medicare cost reports as detailed in Table 4.

Table 4: Unallowable Lobbying Costs				
	FY 2004	FY 2005	FY 2006	Total
Lobbying	**$267**	**$2,617**	**$3,273**	**$6,157**

The unallowable costs included the lobbying activities' portion of association dues.

RECOMMENDATIONS

We recommend that the hospital:

- ensure that it is compliant with the Medicare CoP by following CMS guidance related to commingling of inpatient with observation patients;

- revise and resubmit its Medicare cost reports for 2004, 2005, and 2006, to properly reflect the exclusion of the $294,479 in unallowable costs; and

- ensure that it only reports allowable costs on future Medicare cost reports.

HOSPITAL COMMENTS

In written comments on our draft report, the hospital said that it generally acknowledged and accepted the report, except for the finding that the hospital reported unallowable costs totaling $199,270 for severance pay and related legal costs.

Regarding the former CEO's severance pay, the hospital said that the costs were allowable because they were reasonable, necessary, and proper costs in developing and maintaining the operation of its patient care facilities and activities. Additionally, the hospital said that it had a legal obligation to pay the CEO under the Employment Agreement and the severance payment was an accepted business practice in the health care field.

The hospital's comments are included as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the hospital's comments, we maintain that our findings and recommendations are valid. The Employment Agreement between the CEO and the hospital did not require severance payments because the Employment Agreement was terminated by mutual agreement upon the CEO's resignation. Therefore, the severance pay and related legal costs were not necessary and proper costs related to patient care as required by 42 CFR § 413.9.

APPENDIX

ASPIRUS KEWEENAW
Passion for excellence. Compassion for people.

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P 906.337.6500 ~ aspiruskeweenaw.org

August 6, 2009

Mr. Marc Gustafson
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Re: OIG Draft Report on "Review of Select Medicare Conditions of Participation and Costs Claimed at Aspirus Keweenaw Hospital from August 1, 2004, Through September 30, 2006"
Report Number: A-05-07-00083

Dear Mr. Gustafson:

This is in follow-up to your request for written comments on the U.S. Department of Health and Human Services, Office of Inspector General ("OIG") draft report referenced above. Aspirus Keweenaw ("Hospital") generally acknowledges and accepts the OIG's draft report, except with respect to the OIG's determination that the Hospital reported unallowable costs totaling $199,270 for severance pay and costs related to the resignation of its chief executive officer ("CEO") on its 2004 and 2005 Medicare cost reports. The reasons for that disagreement are set forth below.

Overview of Relevant Medicare Law

As referenced in the draft report, the federal regulations (42 CFR §413.9) and the CMS Provider Reimbursement Manual, Chapter 21, Sections 2102.1 and 2102.2, provide that payments to providers must be based on the reasonable cost of Medicare services and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles related to specific items of revenue and cost.

Reasonable costs of any services are determined in accordance with regulations establishing the method(s) to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs.

Costs may vary from one institution to another because of scope of services, level of care, geographical location and utilization. It is the intent of the Medicare program that providers are reimbursed the actual costs of providing high quality care, regardless of

how widely they may vary from provider to provider, unless found to be substantially out of line with other similar institutions in the same area.

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service.

Costs related to patient care include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Such costs are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, and others.

Aspirus Keweenaw's Position

Aspirus Keweenaw believes that the OIG's finding to disallow the cost of severance payment and legal costs totaling $199,270 related to the termination of its CEO on its 2004 and 2005 cost reports is incorrect and that the facts justify fully such payments.

As more fully described below, the Hospital's position is that the severance payments and related legal costs were allowable because they were reasonable, necessary and proper costs in developing and maintaining the operation of its patient care facilities and activities; the severance payment was consistent with prudent buyer principles; the Hospital had a legal obligation to pay the CEO under the employment agreement; and the severance payment was an accepted business practice in the health care field.

[redacted]

[redacted]

Office of Inspector General Note—The deleted text has been redacted because it contained confidential information that could violate the confidentiality provisions of the CEO's Employment and Severance Agreements.

[redacted]

Office of Inspector General Note—The deleted text has been redacted because it contained confidential information that could violate the confidentiality provisions of the CEO's Employment and Severance Agreements.

[redacted]

the advancement of the delivery of patient care and far from "legal fees and related costs incurred by a provider related to alleged civil fraud or indictment for a criminal act by the provider or its owners, employees, directors, etc., or legal fees for certain anti-union activities" which are the examples of the kind of legal fees not recognized (CMS Provider Reimbursement Manual, Chapter 21, Section 2183).

Finally, we note it is common practice in the health care field for employment arrangements with CEOs to provide continuing compensation (e.g., severance) on termination of the agreement. This is especially true in remote areas, like Laurium, Michigan, where it is difficult to attract qualified individuals to live and work. It is an accepted business practice, and regardless of whether it is specified in an agreement, CEO agreements typically provide for some sort of continuing compensation on termination of employment. The terms of the employment agreement in this case and the payment of severance compensation was based on that reality.

[redacted]

Employment Agreement between the CEO and the hospital did not require the severance payments in the Severance Agreement"-- is not really accurate. Not only did

Office of Inspector General Note—The deleted text has been redacted because it contained confidential information that could violate the confidentiality provisions of the CEO's Employment and Severance Agreements.

the employment agreement require two years of severance payments under the consulting part in the event of termination of the employment agreement, but the amount potentially owed under the employment provisions was an additional seven year's payment.

In summary, Aspirus Keweenaw believes that the severance payment and related legal fees were reasonable, necessary and proper costs incurred in rendering services related to patient care. The costs were appropriate and helpful in maintaining the operation of the Hospital's patient care facilities and activities and actually represented just a fraction of the liability exposure that Aspirus Keweenaw faced if it had litigated this matter. Aspirus Keweenaw had a legal obligation to pay the CEO under the employment agreement. Consistent with prudent buyer principles, the Board acted reasonably and prudently to mitigate the total costs to the Hospital.

Thank you for the opportunity to comment on the OIG draft report. If you have any questions or concerns or need additional information, please do not hesitate to call me.

Sincerely,

ASPIRUS KEWEENAW

Gale Anderson, Chairperson of the Board
[redacted]

Charles Nelson, President
[redacted]

Enclosure

cc: [redacted]

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Office of Inspector General Note—The deleted text has been redacted because it is personally identifiable information.