

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**RHODE ISLAND HOSPITAL
SUBMITTED SOME INACCURATE
WAGE DATA**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Gloria L. Jarmon
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief

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Report No. A-01-17-00509

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

The Centers for Medicare & Medicaid Services (CMS) uses area wage indexes to adjust Medicare payments to reflect local labor prices. CMS calculates new wage indexes annually from wage data (wages, wage-related costs, and hours) submitted by hospitals.

We selected Rhode Island Hospital (the Hospital), located in Providence, Rhode Island, for this review because of its potential to significantly affect Medicare payments in its area in Federal fiscal year (FFY) 2019. The Hospital is part of the Lifespan Health System (Lifespan).

Our objective was to determine whether the Hospital complied with Medicare requirements for reporting wage data used in CMS's calculations of hospital wage indexes for FFY 2019.

How OIG Did This Review

We evaluated the Hospital's compliance with selected Medicare wage data reporting requirements.

Rhode Island Hospital Submitted Some Inaccurate Wage Data

What OIG Found

The Hospital did not always comply with Medicare requirements when reporting its wage data used by CMS for the FFY 2019 hospital wage index calculation. As a result, the Hospital overstated its wages and wage-related costs by \$37,711,870 and overstated its hours by 921,361. These errors occurred because the Hospital officials did not (1) fully understand and follow the Medicare wage-data-reporting requirements in the *CMS Provider Reimbursement Manual* (the Manual) and (2) have adequate review and reconciliation procedures to ensure that the wage data it reported to CMS were accurate, allowable, supportable, and in compliance with Medicare requirements.

Some errors raised the Hospital's average hourly wage and other errors lowered it. Overall, for this year, the net effect of the errors did not cause a material change to the Hospital's wage index. Because of the expected immaterial effect on payments, we did not request that the Medicare administrative contractor make any corrections to the Hospital's wage data for the FFY 2019 wage-index cycle.

What OIG Recommends and Rhode Island Hospital's Comments

We recommend that the Hospital (1) ensure that all personnel involved in Medicare wage-data reporting are fully trained in compliance with the requirements in the Manual and (2) strengthen review and reconciliation procedures to ensure that the Medicare wage data it reports to CMS in the future are accurate, allowable, supportable, and in compliance with Medicare requirements.

In written comments on our draft report, Lifespan, on behalf of the Hospital, concurred with four of our six findings. Lifespan disagreed that the Hospital (1) could not support its contracted labor wages and associated hours and (2) incorrectly reported its nonphysician practitioner costs as Part A. Lifespan described the Hospital's efforts to capture and produce more accurate cost report data. However, Lifespan did not indicate whether the Hospital concurred with our recommendations.

We maintain that our findings and recommendations are valid. We acknowledge the Hospital's right to appeal our findings.

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INTRODUCTION

WHY WE DID THIS REVIEW

Medicare acute-care hospitals must report wage data annually to the Centers for Medicare & Medicaid Services (CMS). Wage data include wages, associated hours, and wage-related costs (i.e., allowable fringe benefits). CMS uses the wage data to calculate acute-care-hospital wage indexes, which measure geographic area labor market prices relative to a national average. Federal law requires CMS to annually adjust Medicare hospital payments to reflect local labor markets; CMS uses area wage indexes to do this.

Our prior reviews, listed in Appendix B, found that hospitals often reported inaccurate wage data. Inclusion of inaccurate wage data in wage-index calculations may lead to payment adjustments that do not accurately reflect local labor prices.

We selected Rhode Island Hospital (the Hospital), located in Providence, Rhode Island, for this review because of its potential to significantly affect Medicare payments in its area¹ in 2019.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for reporting wage data used in CMS's calculations of hospital wage indexes for Federal fiscal year (FFY) 2019.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

Medicare Payments in the Inpatient Prospective Payment System

Under the inpatient prospective payment system (IPPS), Medicare pays hospitals predetermined, diagnosis-related rates for patient discharges (under Part A). The primary objective of the IPPS is to create incentives for hospitals to operate efficiently, while ensuring that payments are adequate to compensate hospitals for their reasonable costs in furnishing necessary high-quality care to Medicare beneficiaries.

¹ The Hospital is located in an urban core-based statistical area, as defined by the Office of Management and Budget, which includes Providence, Rhode Island, and New Bedford and Fall River, Massachusetts.

Wage Data and Wage Indexes

CMS must annually adjust IPPS payments (Part A payments) to reflect labor prices in local labor markets (Social Security Act (the Act) § 1886(d)(3)(E)). CMS uses area wage indexes derived from wage data to make these adjustments. CMS collects wage data from hospitals annually through the hospitals' Medicare cost reports. Wage data include wages, associated hours, and wage-related costs (i.e., allowable fringe benefits). In addition, CMS collects occupational-mix survey data from hospitals every 3 years and uses it to adjust the annual wage data for management's staffing decisions.²

CMS determines a wage index by dividing the occupational-mix adjusted Part A average hourly wage (AHW) for acute-care hospitals in a geographic area by the national occupational-mix adjusted Part A AHW for acute-care hospitals.³ CMS adjusts IPPS payments upward for areas with wage indexes greater than 1 (local AHWs higher than the national AHW) and downward for areas with wage indexes lower than 1 (local AHWs lower than the national AHW). Variations of the hospital wage index also affect payments to other types of providers under other prospective payment systems.⁴

To calculate wage indexes, CMS uses hospital wage data from 4 years earlier to allow time for the collection of complete cost report data from all IPPS hospitals and for reviews of hospital wage data by CMS's Medicare administrative contractors (MACs). For example, CMS based the wage indexes for 2019 on wage data collected from hospitals' Medicare cost reports for their fiscal years that began during FFY 2015.

Budget Neutrality

CMS must update wage indexes annually in a manner that ensures that aggregate payments to hospitals are not affected by changes in the indexes (that is, wage index adjustments must be "budget neutral" on a nation-wide basis) (the Act, § 1886(d)(3)(E)).

² The occupational-mix adjustment controls for the effect of hospitals' employment choices on the wage index. For example, to provide nursing care, hospitals choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the price of labor.

³ The hospital wage index applied to IPPS payments is a measure of the local price of labor for workers' whose services are covered by Part A. Wage data for employees and contractors whose services are not covered by Medicare at all, or whose services are covered by Part B, are excluded from the calculation of the hospital wage index.

⁴ The IPPS hospital wage index or a modified version also applies to other providers, such as outpatient hospitals, skilled nursing facilities, long-term care hospitals, home health agencies, inpatient rehabilitation facilities, inpatient psychiatric facilities, and hospices. Throughout this report, we use "wage index" to refer only to the IPPS wage index used to calculate IPPS hospital payments.

Inaccurate Hospital Wage- and Occupational-Mix Data

Hospitals are responsible for submitting accurate wage- and occupational-mix data. During wage-index development, hospitals, MACs, and CMS have the opportunity to identify and correct inaccurate wage data. CMS sets deadlines for correction requests.

Except in certain very limited circumstances,⁵ if inaccurate wage data are not identified by the specified deadlines before the payment year starts, the original data are used by CMS to calculate wage indexes for the payment year. This decreases payment accuracy. Because of the prospective nature of current payment systems, CMS has no mechanism to retroactively adjust final wage indexes and recover overpayments or remedy underpayments⁶ resulting from inaccurate wage data.

Related Office of Inspector General Reviews

In our most recent review,⁷ we described significant vulnerabilities in the wage-index system that we observed during our previous reviews. We recommended that CMS revisit the possibility of comprehensive reform. In the absence of a movement toward comprehensive reform, we made several statutory proposals aimed at improving payment accuracy. For example, we recommended that CMS seek legislative authority to penalize hospitals that submit inaccurate or incomplete wage data in the absence of misrepresentation or falsification. CMS concurred with most of our recommendations and is considering whether to recommend them for inclusion in the President's next budget.

Rhode Island Hospital

The Hospital, located in Providence, Rhode Island, is a 719-bed, not-for-profit, acute-care teaching hospital. The Hospital is the largest hospital in its State and part of the Lifespan Health System (Lifespan).

⁵ CMS will make a midyear correction to an individual hospital's wage index during the payment year and apply the corrected wage index for the remainder of the year. Federal regulations specify that CMS may make a midyear correction to a hospital's wage index only if the hospital shows that its MAC or CMS made an error in tabulating its data and that the hospital either could not have known about the error or did not have the opportunity to correct the error before the beginning of the FFY (42 CFR § 412.64(k)).

⁶ In our prior reports, we referred to payments calculated based on inaccurate wage data as "overpayments" or "underpayments," even though we were referring to improper payments caused by incorrect rates rather than by questionable claims submission or claims processing (the more usual connotation of "overpayment" or "underpayment").

⁷ Significant Vulnerabilities Exist in Hospital Wage Index System for Medicare Payments (A-01-17-00500).

The Hospital's FFY 2015 Medicare cost report covers the period from October 1, 2014, through September 30, 2015.⁸ We selected the Hospital for this review because of its potential to significantly affect Medicare payments in its area in 2019.⁹

HOW WE CONDUCTED THIS REVIEW

Our audit covered the \$645,846,831 in wages and wage-related costs and 14,873,440 in hours for employees, home office staff, and contractors that the Hospital reported to CMS on the wage-data worksheets of its FFY 2015 Medicare cost report. We evaluated the Hospital's compliance with selected Medicare wage-data-reporting requirements. We limited our review of the Hospital's internal controls to those related to accumulating and reporting wage data for its FFY 2015 cost report. This report does not represent an assessment of any claims submitted by the Hospital for Medicare reimbursement.

We conducted this 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 objective.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The Hospital did not always comply with Medicare requirements for reporting wage data in its FFY 2015 Medicare cost report. As a result, the Hospital overstated its occupational-mix-adjusted Part A wages and wage-related costs by \$37,711,870 and overstated Part A hours¹⁰ by 921,361. Specifically, the Hospital overstated:

- contract labor wages by \$16,387,450 and hours by 196,472,

⁸ Hospitals may have different Medicare cost reporting periods based on their individual fiscal year start date. "FFY 2015" Medicare cost reports include data for hospital fiscal years beginning during FFY 2015 (beginning on or after October 1, 2014, and before October 1, 2015). Accordingly, because its fiscal year begins October 1, Rhode Island Hospital's FFY 2015 cost report covers the period of October 1, 2014, through September 30, 2015.

⁹ The Hospital's wage data accounts for approximately 22 percent of the total wages reported by all hospitals in its core-based statistical area. As such, the Hospital has the potential to significantly impact the overall average hourly wage, and the wage index, for the entire area.

¹⁰ "Part A wages" refers to the numerator in the average hourly wage calculation for an individual hospital, core-based statistical area, or rural area. The numerator includes salaries, wages, and wage-related costs pertaining to Part A services, as opposed to Part B or non-Medicare services. "Part A hours" are the hours associated with those Part A wages.

- employee salaries by \$14,715,652 and hours by 724,889,
- home office wages by \$4,607,521, and
- employee wage-related costs by \$2,001,247.

These errors occurred because the Hospital did not (1) fully understand and follow the Medicare wage-data-reporting requirements in the CMS *Provider Reimbursement Manual* (the Manual) and (2) have adequate review and reconciliation procedures to ensure that the wage data it reported to CMS were accurate, allowable, supportable, and in compliance with Medicare requirements.

Some errors raised the Hospital's average hourly wage and other errors lowered it. Overall, for this year, the net effect of the errors did not cause a material change to the Hospital's wage index. The incorrect wage data decreased the Hospital's occupational-mix-adjusted average hourly wage from \$43.67 to \$43.54 and decreased the Hospital's wage index by approximately 0.15 percent.¹¹ Because of the expected immaterial effect on payments, we did not request that the MAC make any corrections to the Hospital's wage data for the FY 2019 wage-index cycle. However, if the errors continue in the future, there could be a more significant impact in subsequent years.¹²

FEDERAL REQUIREMENTS FOR REPORTING HOSPITAL WAGE DATA

Federal regulations (42 CFR §§ 412.52, 413.24, and 413.20) require that IPPS hospital costs reported for Medicare must be supported by adequate cost data (i.e., cost data that are accurate, auditable, and sufficiently detailed to accomplish the intended purposes).¹³ In addition, chapter 40 of the Manual contains instructions for completing the Medicare cost report, Form CMS 2552-10, including specific instructions on what to report on each line of the wage-data worksheets (Worksheet S-3, parts II, III, and IV of the Medicare cost report).

¹¹ We informed the Hospital of the findings during the audit and, also discussed them with the MAC. The Hospital did not request that we or the MAC make corrections.

¹² For example, if the Hospital corrects the methodology that led to the overstatement of hours this year, but not the methodology that led to the overstatement of the wages, the Hospital's average hourly wage could be overstated in future years.

¹³ "All hospitals participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of (42 CFR §§ 413.20 and 413.24)" (42 CFR § 412.52). Federal regulations state: "Providers receiving payment on the basis of reimbursement cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors" (42 CFR § 413.24(a)). "The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purpose for which it is intended" (42 CFR § 413.24 (c)).

CONTRACTED LABOR WAGES AND HOURS

The Manual, section 4005.2, states that, for contract labor, the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and nonlabor costs are not clearly specified in the contract, other supporting documentation is required, such as a representative sample of invoices which specify the wage costs, hours, and nonlabor costs. Attestations or declarations from the vendor or hospital are not acceptable in lieu of supporting documentation for wages, hours, wage-related costs, and nonlabor costs. Hospitals must be able to provide such documentation when requested by the MAC.

The Hospital reported \$16,387,450 in wages and 196,472 associated hours for physician Part A contracted labor that were not supported by adequate documentation. The contracts did not always specify hours. For example, in some instances, the contracts specified the amount to be paid per year or month without specifying hours. There were no supporting invoices that specified labor costs and hours.

To determine the amounts to report on the line for “Contract Labor-Physician Part A Administrative” on Worksheet S-3, part II, the Hospital relied on time studies to estimate the total hours worked by each physician under contract and the percentage of time each spent on Part A administrative tasks. Then, the Hospital created a weighted average for all physicians who worked in a department, regardless of which specific contract they worked under. This aggregated contracts with stated hours and costs¹⁴ with contracts with no stated hours.¹⁵ The Hospital applied the aggregate percentages for each department to the amounts paid under all contracts for the department.¹⁶ As such, we could not verify that the contracted physicians were paid based on the hours they actually worked.

Hospital officials did not fully understand and follow the cost-report requirements in the Manual. Specifically, hospital officials did not understand that instructions from nonwage data sections of the cost report do not apply to wage data. Hospital officials stated that costs in certain medical departments, which are treated as overhead, must be allocated based on a statistic from Worksheet B (Cost Allocation) of the Medicare cost report. However, Worksheet B is for the purpose of allocating costs among cost centers and not distinguishing contracted Part A physician costs and hours from Part B physician costs and hours for purposes of allocation of wage data. In addition, hospital officials did not understand that time studies

¹⁴ For example, one contract listed three particular doctors for a total of 50 hours per week for medical director case management services for a specified amount per year.

¹⁵ For example, another contract listed administrative, supervisory, and teaching services to be provided to the department of medicine by over 90 doctors for a specified dollar amount with no specified hours.

¹⁶ For example, 38 percent of the amounts paid for all contracts for the department of medicine were determined to be for Part A administrative services, because as a whole physicians working under multiple contracts were estimated to have spent 38 percent of their contracted time on Part A administrative services on the basis of time studies.

should not be used to support actual hours worked, although they can be used to estimate the percentage of time worked on each category (e.g., administrative versus patient care). Hospital officials stated that “in the past, Medicare has required/only accepted what the extrapolated hours (and percentages) were based on the time studies.” Finally, hospital officials did not understand that the instructions for salaried (employed) physicians do not apply to contracted physicians. While the Manual allows a weighted average for allocating compensation for salaried physicians (including physicians paid through affiliated agreements), the requirements for contracted labor are more precise (i.e., the documentation must support actual wages and hours versus estimates).

As a result of unsupported contracted labor wages and hours, after applying the Hospital’s occupational-mix adjustment factor, the Hospital overstated its Part A wages and hours by \$16,387,450 and 196,472 associated hours, which overstated its average hourly wage by \$0.68.

EMPLOYEE SALARIES AND HOURS

Nonphysician Practitioner Costs Incorrectly Reported as Part A

Worksheet S-3, part II, of the Medicare cost report is designed to subtract the salaries of employees whose services are covered under Part B from total salaries to arrive at the total Part A salaries used to calculate the wage index that adjusts Part A payments for local wage prices. Services provided by nurse practitioners and certain other nonphysician practitioners are covered by Part B.¹⁷

The Hospital employed nurse practitioners and other nonphysician practitioners and reported their salaries on line 1 (total salaries) of Worksheet S-3, part II. At some point prior to 1998, the Hospital’s management decided not to bill Part B for the services of the nurse practitioners. Hospital officials stated that, because of this decision, the Hospital was not required to report these salaries as Part B for subtraction from total salaries for wage index purposes. However, the purpose of the wage index is to adjust Part A payments for the local wages of employees whose services are covered under Part A. Nurse practitioner services are covered under Part B. The fact that the Hospital did not bill Part B for nurse practitioner services does not make them covered by Part A.

As a result of not reporting nurse practitioner salaries on the appropriate Part B line, the salaries of these employees were not subtracted from total salaries (even though their services were covered by Part B) and were incorrectly included as Part A salaries for the wage-index calculation.

¹⁷ The Act and Medicare regulations provide that, as a general matter, services provided by nurse practitioners and physicians are covered by Part B, not Part A (the Act §§ 1861(b) and 1861(s)(2)(K)(ii) and 42 CFR §§ 409.10, 410.10, and 410.75).

As a result of this error, after applying the Hospital's occupational-mix adjustment factor, the Hospital overstated its Part A wages by \$9,090,245 and overstated the associated hours by 151,399, which overstated its average hourly wage by \$0.22.

Salaries Reported Without Hours

The Manual, section 4005.2, states that associated hours should be reported for all salaries and wages, and "if the hours cannot be determined, then the associated salaries must not be included" in the wage data.

The Hospital incorrectly reported salaries for variable pay (i.e., bonus or incentive pay) and payroll transfer amounts¹⁸ without associated hours.

For variable pay, the Hospital could not provide a payroll report by specific employee and earnings code (showing all earnings code¹⁹ for each employee). The Hospital stated there are no hours that go specifically with the variable "type of pay." Instead, the Hospital provided a payroll report that was summarized by cost center and job code. Because the payroll report was not summarized by employee, we could not reconcile the variable earnings to the primary source for the "regular hours" worked (payroll report). We could not confirm that the employees themselves had actual hours worked (for all types of pay).²⁰

For payroll transfer, the Hospital does not track the hours associated with dollars that get transferred through the payroll transfer accounts. These salaries are moved via a journal entry between entities, and the Hospital is not able to account for the hours that go with these salaries.

As a result of the Hospital's errors, after applying the Hospital's occupational-mix adjustment factor, the Hospital overstated its Part A wages by \$5,625,407, which overstated its average hourly wage by \$0.48.

Overstated Hours

The Manual, section 4005.2, states that hospitals should report direct salaries and wages paid to hospital employees on line 1 (total salaries) of Worksheet S-3, part II. Hours related to

¹⁸ The payroll transfer accounts are for employees who split their time between departments or affiliated hospitals (all owned by Lifespan). The Hospital makes journal entries to transfer salary expenses to the appropriate department or affiliate.

¹⁹ The Hospital establishes separate codes for each earnings type used in the payroll system (regular, overtime, sick pay, vacation, etc.).

²⁰ For example, if the Hospital had provided a payroll report that was summarized by employee, we would have been able to confirm that employees who received salaries for variable pay also worked a specific number of "regular" hours.

contracted services should be reported on different lines of S-3, part II. The Manual, section 4005.2, also states that associated hours should be reported for all salaries and wages, and “if the hours cannot be determined, then the associated salaries must not be included” in the wage data.

The Hospital overstated hours related to salaries by incorrectly including hours for contracted services and reimbursed payroll.²¹ Specifically, the Hospital reported hours for contract labor on the same line as paid hours related to salaries for hospital employees (instead of segregating them on the appropriate lines of the wage-data worksheet). In addition, the Hospital overstated the hours associated with reimbursed payroll amounts because it did not track and remove these hours through a reclassification to the line for excluded area salaries.

The Hospital tracks contracted labor amounts via its payroll register, which includes amounts paid to both salaried employees and contracted individuals. Hospital officials manually enter contracted labor data (dollars and hours) into the hospital’s payroll system in order to track the data through payroll reports and the general ledger. For wage-data-reporting purposes, the Hospital subtracts the total dollars for amounts paid under contract to arrive at the total salaries reported on line 1 (total salaries) of Worksheet S-3, part II. However, when the Hospital removed the total dollars for contracted labor, it did not subtract the corresponding hours for contracted labor.

The Hospital does not track the hours associated with dollars that get transferred through the reimbursed payroll account. For reimbursed payroll, the Hospital removed the salaries through a reclassification to excluded area salaries. However, we could not identify the associated hours and confirm that they were also removed.²²

As a result of the Hospital’s errors, after applying the Hospital’s occupational-mix adjustment factor, the Hospital overstated Part A hours by 573,490 (contracted labor), which understated its average hourly wage by \$2.19. The Hospital also overstated the hours associated with reimbursed payroll salaries, which understated its average hourly wage.

²¹ The Hospital is the home base for teaching physicians that rotate out to other hospitals. The other hospitals reimburse the Hospital for the salaries of those employees for the time they worked at the other hospitals. The salary expense is initially recorded on the Hospital’s general ledger but is later removed through the “payroll billed” general ledger account (the expense and the subsequent reimbursement net to zero on the general ledger). For wage-reporting purposes, the Hospital records the reimbursed payroll salaries as part of the total salaries (line 1) on Worksheet S-3, part II, but subsequently removes them from Part A wages through a reclassification to excluded area salaries.

²² Since the Hospital cannot track the hours for reimbursed payroll, it should not report the corresponding salaries on either line 1 (total salaries) nor on the line for excluded area salaries.

Combined Effect of Errors in Reporting Hospital Salaries and Hours

The combined effect of the errors in reporting salaries and related hours, after applying the Hospital's occupational-mix adjustment was that the Hospital overstated Part A wages by \$14,715,652 and hours by 724,889. This understated the Hospital's average hourly wage by \$1.47.

HOME OFFICE WAGES AND HOURS

The Manual, section 4005.2, states that it is important for hospitals to ensure that their wage data are accurate.

On home office line of Worksheet S-3, part II, a hospital may report salaries, wage-related costs, and hours relating to personnel affiliated with their health care chain's (chain's) home office who provide services to the hospital, such as centralized accounting, purchasing, human resources, and management. The Manual states that the reported amounts must be based on recognized methods of allocating an individual's home office/related organization salary to the hospital. All costs for any related organization must be shown as the costs to the related organization.

The Manual, part I, section 2150.3A, states that a home office must exclude unallowable costs before allocating costs to its chain components.

The Manual, part I, section 2153, states: "The home office cost statement constitutes the documentary support required of the provider to be reimbursed for home office costs and equity capital in the provider's cost report. The financial records of the home office, in turn, are the necessary support for the data in the home office cost statement."

The Hospital overstated home office wages²³ because it based its allocation on an inaccurate "pool" of home office salaries.²⁴ When determining the pool of home office costs to be allocated, the Hospital overstated the pooled amount because it (1) included certain expenses in the pool twice and (2) used an incorrect column from the home office cost report instead of the correct pooled allocation column. The Hospital should have allocated home office wages of \$47,682,736²⁵ instead of the reported \$52,290,257.

The Hospital stated that the errors in the home office allocation pool occurred because hospital officials did not properly set up the home office work papers.

²³ Wages here means salaries plus wage-related costs.

²⁴ The Hospital was allocated 60 percent of total pooled home office costs of \$87,150,529. The allocation percentage was based on the Hospital's percentage of total operating expenses (less management fees) for the Lifespan Health System.

²⁵ Total correct pooled amount of \$79,471,319 multiplied by 60 percent.

As a result of overstating home office wages, after applying the Hospital's occupational-mix adjustment factor, the Hospital overstated its Part A wages by \$4,607,521, which overstated its average hourly wage by \$0.39.

EMPLOYEE WAGE-RELATED COSTS

On various lines of Worksheet S-3, part II, a hospital may report wage-related costs that meet the reasonable cost provisions of Medicare. The Manual, chapter 40, section 4005.4, states that the hospital must provide the contractor with a complete list of all core wage-related costs included on those lines. Worksheet S-3, part IV, provides for the identification of all wage-related costs.

The Manual, section 4005.4, outlines the policy under which hospitals should report costs for defined benefit pension plans (line 4 of Worksheet S-3, part IV). Pension costs for a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider. The Manual states that the annual pension costs to be included in the wage index must be the average annual employer contributions made by, or on behalf of, the provider (on a cash basis) to all defined benefit plans covered under this section during the averaging period. The Manual further states that, beginning with the FY 2017 wage index, generally, the averaging period is based on the base cost reporting period, plus the prior two cost reporting years (36 months).

Hospitals may report in wage data the wage-related costs appearing on CMS's list of "core" costs, which is meant to include all commonly recognized fringe benefits that contribute significantly to the wage costs of a hospital (currently, the list is lines 1 through 23 of Worksheet S-3, part IV, of the Medicare Cost Report). Tuition reimbursement is an example of a core wage-related cost. The Manual states, that among other things, an "other wage-related cost" must meet a materiality threshold. The total cost of each "other wage-related cost" for employees whose services are paid under IPPS must exceed 1 percent of total salaries after the direct excluded salaries are removed.

The Hospital included unallowable pension costs as part of the wage-related costs that it reported on Worksheet S-3 part II. Specifically, the Hospital incorrectly included pension costs from its general ledger instead of the pension costs that it calculated using its average annual contributions during the 36-month averaging period. The Hospital identified these costs as part of the total wage-related core costs that it identified on Worksheet S-3, part IV, line 4 (defined benefit plan) but did not properly allocate them to S-3, part II, resulting in overstated pension costs of \$1,924,021. In addition, the Hospital used an incorrect averaging period to calculate the average annual contributions, which resulted in an understatement of \$23,563. As a result, the Hospital overstated wage-related costs by \$1,900,458 on Worksheet S-3, part II.²⁶

²⁶ The Hospital submitted corrected pension costs to its MAC, but the MAC has not yet made all of the necessary corrections.

The Hospital reported \$100,789 in employee assistance program (EAP)²⁷ costs in core wage-related costs, categorizing EAP as tuition reimbursement. EAP is not on the CMS list of “core” costs. Additionally, the Hospital agreed that the EAP was not a tuition reimbursement cost and did not meet the requirements of a core wage-related cost. To be reported as a wage-related cost, the EAP would have to meet the requirements to be an “other wage-related cost,” because it is not on the core list. However, the cost of EAP is unallowable as an “other wage related cost” because it did not meet the 1 percent threshold.²⁸

As a result of the Hospital’s errors, after applying the Hospital’s occupational-mix adjustment factor, the Hospital overstated its Part A wages by \$2,001,247, which overstated its average hourly wage by \$0.20.

CAUSES OF WAGE-DATA-REPORTING ERRORS

These reporting errors occurred because Hospital officials did not:

- fully understand and follow the Medicare wage-data-reporting requirements in the Manual and
- have adequate review and reconciliation procedures to ensure that the wage data it reported to CMS were accurate, allowable, supportable, and in compliance with Medicare requirements.

UNDERPAYMENTS TO RHODE ISLAND HOSPITAL

The Hospital overstated Part A wages by \$37,711,870 and overstated Part A hours by 921,361. Some errors raised the Hospital’s average hourly wage and other errors lowered it. Overall, for this year, the net effect of the errors did not cause a material change to the Hospital’s wage index. The incorrect wage data decreased the Hospital’s occupational-mix-adjusted average hourly wage from \$43.67 to \$43.54 and decreased the Hospital’s wage index by approximately 0.15 percent. Because of the expected immaterial effect on payments, we did not request that the MAC make any corrections to the FY 2019 wage-index cycle. However, if the errors continue to occur in the future, there could be a more significant impact in subsequent years.

²⁷ Lifespan’s EAP is a free service available as a benefit to all employees and their family members and provides resource information on family and relationship issues, raising children, adoption assistance, and more.

²⁸ It may also not meet other requirements to be an “other wage-related cost,” such as being an IRS-recognized fringe benefit reported by the Hospital to the IRS as income to the employee. Because the EAP did not meet the 1 percent threshold, we did not move forward with determining whether the other requirements were met.

RECOMMENDATIONS

We recommend that the Rhode Island Hospital:

- ensure that all personnel involved in Medicare wage-data reporting are fully trained in compliance with the requirements in the Manual and
- strengthen review and reconciliation procedures to ensure that the Medicare wage data it reports to CMS in the future are accurate, allowable, supportable, and in compliance with Medicare requirements.

RHODE ISLAND HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

RHODE ISLAND HOSPITAL COMMENTS

In written comments on our draft report, Lifespan, on behalf of the Hospital, agreed with our findings that the Hospital overstated (1) employee salaries without hours, (2) hours related to employee salaries, (3) home office wages, and (4) employee wage-related costs. Lifespan disagreed with our findings that the Hospital (1) could not support its contracted labor wages and hours and (2) incorrectly reported salaries for its nonphysician practitioners as Part A. Lifespan described the Hospital's efforts to capture and produce more accurate cost report data. However, Lifespan did not indicate whether the Hospital concurred with our recommendations.

Lifespan's comments on behalf of the Hospital are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate the Hospital's efforts to capture and produce more accurate cost report data. We maintain that our findings related to contracted labor wages and hours and salaries for nonphysician practitioners are valid.

Below is a summary of the reasons that Lifespan, on behalf of the Hospital, did not agree with two of our findings and our responses.

CONTRACTED LABOR WAGES AND HOURS

Rhode Island Hospital Comments

Lifespan, on behalf of the Hospital, disagreed that the Hospital could not support its contracted labor wages and associated hours (physician Part A). Lifespan officials stated that the Hospital has always calculated the hours it reports for contract labor "based on the average hours from the physician timesheets, extrapolated to 52 weeks." Lifespan officials further stated that "the hours in a physician's contract state what is estimated to be expected, and not actual." They

maintained that the only way the Hospital can allocate the costs for certain overhead departments is based on a statistic from Worksheet B (Cost Allocation) of the Medicare cost report. This statistic is the compilation of all the physicians' timesheets in those departments on a weighted average basis.

Office of Inspector General Response

We disagree that the Hospital is using an acceptable methodology to determine the amounts it reports for physician Part A contracted labor. We maintain that time studies should not be used to support actual hours worked. The documentation must support actual wages and hours versus estimates.

The Manual states that, for contract labor, the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and nonlabor costs are not clearly specified in the contract, other supporting documentation is required, such as a representative sample of invoices that specify the wage costs, hours, and nonlabor costs. Attestations or declarations from the vendor or hospital are not acceptable in lieu of supporting documentation for wages, hours, wage-related costs, and nonlabor costs.

EMPLOYEE SALARIES AND HOURS

Nonphysician Practitioner Costs Incorrectly Reported as Part A

Rhode Island Hospital Comments

Lifespan officials, on behalf of the Hospital, disagreed that the Hospital incorrectly reported its nonphysician practitioner costs as Part A. Lifespan officials stated that the Hospital reached an agreement with CMS on appeal of its submission of its fiscal year 1998 cost report. As part of that settlement, Lifespan officials stated that CMS agreed that nonphysician practitioners that do not bill for their services shall be considered Part A costs and be included as hospital allowable costs and, therefore, included as such for calculations like the wage index. Lifespan officials further stated that the Hospital provided us with a copy of the agreement with CMS.

Office of Inspector General Response

We disagree that the Hospital correctly reported employee salaries and hours for its nonphysician practitioners as Part A. We maintain that the services of nurse practitioners and certain other nonphysician practitioners are covered by Part B, not Part A. Accordingly, the salaries and hours for these employees should have been subtracted from the total salaries that the Hospital reported on line 1 of Worksheet S-3, Part II.

We acknowledge that the Hospital provided a partial copy of a settlement (related to the treatment of nonphysician practitioners on its fiscal year 1998 cost report) with its former Medicare fiscal intermediary. However, this billing agreement did not relate to how the

salaries of these individuals should be reported for wage index purposes. Further, the settlement does not relate to the criterion we cited in our finding. Specifically, the settlement relates to Medicare reasonable cost provisions rather than the wage data instructions. (The wage data instructions have separate requirements that are intended to calculate the Hospital's average hourly wage (Part A)). The fact that the Hospital did not bill Part B for the services of certain nonphysician practitioners (and may have included their costs as Part A costs on the Hospital's cost report) does not mean the *salaries* of these employees should be considered Part A salaries for the wage index calculation. If the salaries are associated with services that are billable under Part B, these salaries must be subtracted from the total salaries reported on line 1, regardless of whether the Hospital billed Part B for the services or not.

OTHER MATTERS

RELIANCE ON POOLING METHOD OF ALLOCATION FOR HOME OFFICE WAGE COSTS

According to section 3902 of the Manual, when completing its Home Office Cost Statement, a chain should first directly assign costs to components, then functionally allocate costs whenever possible, and lastly pool the remaining costs and allocate them to components on a reasonable allocation basis, such as percentage of total cost. The purpose of the order of these methods is to make allocations as accurate as possible. According to chapter 21 of the Manual, section 2150.3, home office costs should first be allocated based on the direct and functional methods before any residual amounts (that could not be directly or functionally allocated) are allocated on a reasonable basis.

Lifespan and the Hospital used only the pooled allocation methodology to determine the amount of home office wages to report on the home office line of Worksheet S-3, part II without first allocating home offices wages based on the direct and functional methods.

Although pooling is an acceptable allocation methodology, it is the least preferred method, according to the Manual, and should only be used to allocate any residual amounts that could not be directly or functionally allocated.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the \$645,846,831 in wages and wage-related costs and 14,873,440 in hours for employees, home office staff, and contractors that the Hospital reported to CMS on the wage-data worksheets of its FFY 2015 Medicare cost report. We evaluated compliance with selected Medicare wage-data-reporting requirements. We limited our review of the Hospital's internal controls to those related to accumulating and reporting wage data for its FFY 2015 cost report. This report does not represent an assessment of any claims submitted by the Hospital for Medicare reimbursement.

Our audit work included contacting the Hospital, Lifespan, and the Hospital's MAC from July 2017 through August 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, standards, and guidance;
- obtained an understanding of the Hospital's procedures for reporting wage data;
- obtained Hospital and Lifespan payroll, general ledger, accounts payable, and other reports and work papers to support the reported wage data and compared the wage data to the supporting documents; and
- discussed our findings with Hospital officials.

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.

APPENDIX B: OFFICE OF INSPECTOR GENERAL REVIEWS OF HOSPITALS' WAGE DATA

Report Title	Report Number	Date Issued
<i>St. Joseph Hospital and Medical Center Submitted Some Inaccurate Wage Data</i>	<u>A-01-17-00510</u>	May 2019
<i>Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments</i>	<u>A-01-17-00500</u>	November 2018
<i>Sierra Nevada Memorial Hospital Did Not Accurately Report Certain Wage Data, Resulting in Overpayments to California Hospitals</i>	<u>A-09-16-02044</u>	September 2017
<i>Alta Bates Medical Center Inaccurately Reported Wage Data, Resulting in Medicare Overpayments</i>	<u>A-09-14-02035</u>	March 2017
<i>Nantucket Cottage Hospital Did Not Accurately Report Certain Wage Data, Resulting in Overpayments to Massachusetts Hospitals</i>	<u>A-01-15-00502</u>	March 2017
<i>Dominican Hospital Reported Overstated Wage Data, Resulting in Medicare Overpayments</i>	<u>A-09-14-02032</u>	June 2016
<i>Danbury Hospital Reported Overstated Wage Data, Resulting in Medicare Overpayments</i>	<u>A-01-14-00506</u>	January 2016
<i>Review of the Altoona Regional Health System's Reported Fiscal Year 2006 Wage Data</i>	<u>A-03-08-00019</u>	August 2009
<i>Review of Via Christi Regional Medical Center's Reported Fiscal Year 2005 Wage Data</i>	<u>A-07-07-02726</u>	December 2008
<i>Review of Thomas Jefferson University Hospital's Reported Fiscal Year 2006 Wage Data</i>	<u>A-03-07-00024</u>	November 2008
<i>Review of Kaiser Foundation Hospital-Vallejo's Reported Fiscal Year 2005 Wage Data</i>	<u>A-09-07-00083</u>	September 2008
<i>Review of Ochsner Foundation Hospital's Reported Fiscal Year 2005 Wage Data</i>	<u>A-01-08-00519</u>	August 2008
<i>Review of Henry Ford Hospital's Reported Fiscal Year 2005 Wage Data</i>	<u>A-05-07-00063</u>	August 2008
<i>Review of Touro Infirmary's Reported Fiscal Year 2005 Wage Data</i>	<u>A-01-08-00513</u>	July 2008

Report Title	Report Number	Date Issued
<i>Review of West Jefferson Medical Center's Reported Fiscal Year 2005 Wage Data</i>	A-01-08-00516	July 2008
<i>Review of Tulane Medical Center's Reported Fiscal Year 2005 Wage Data</i>	A-01-08-00518	July 2008
<i>Review of Broward General Medical Center's Reported Fiscal Year 2006 Wage Data</i>	A-04-07-06034	July 2008
<i>Review of East Jefferson General Hospital's Reported Fiscal Year 2005 Wage Data</i>	A-01-08-00515	June 2008
<i>Review of Methodist Hospital Wage Data for the Fiscal Year 2009 Wage Indexes</i>	A-06-07-00098	June 2008
<i>Review of Duke University Medical Center's Reported Fiscal Year 2006 Wage Data</i>	A-01-07-00511	April 2008
<i>Review of St. Peter's University Hospital's Reported Fiscal Year 2005 Wage Data</i>	A-02-07-01047	February 2008
<i>Review of UMass Memorial Medical Center's Reported Fiscal Year 2006 Wage Data</i>	A-01-07-00509	January 2008
<i>Review of Hospital Wage Data Used To Calculate Inpatient Prospective Payment System Wage Indexes²⁹</i>	A-01-05-00504	February 2007
<i>Review of University of California, Davis Medical Center's Reported Fiscal Year 2004 Wage Data</i>	A-09-06-00024	September 2006
<i>Review of University of California, Irvine Medical Center's Reported Fiscal Year 2004 Wage Data</i>	A-09-06-00025	September 2006
<i>Review of University of California, Los Angeles Medical Center's Reported Fiscal Year 2004 Wage Data</i>	A-09-06-00026	September 2006
<i>Review of University of California, San Diego Medical Center's Reported Fiscal Year 2004 Wage Data</i>	A-09-06-00027	September 2006
<i>Review of University of California, San Francisco Medical Center's Reported Fiscal Year 2004 Wage Data</i>	A-09-05-00039	September 2006

²⁹ This report consolidates the results of our first 21 reviews of hospitals' wage data.

Report Title	Report Number	Date Issued
<i>Review of the North Shore University Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes</i>	A-02-05-01008	May 2006
<i>Review of Controls to Report Wage Data at Sarasota Memorial Hospital for the Period of October 1, 2002, through September 30, 2003</i>	A-04-05-02001	May 2006
<i>Review of Controls to Report Wage Data at Florida Hospital Heartland for the Period January 1, 2003, through December 31, 2003</i>	A-04-05-02002	May 2006
<i>Review of Valley Baptist Medical Center's Reported Fiscal Year 2003 Wage Data</i>	A-06-06-00037	May 2006
<i>Review of the Hospital Wage Index at Baylor University Medical Center</i>	A-06-06-00038	May 2006
<i>Review of the Saint Francis Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes</i>	A-02-05-01004	April 2006
<i>Review of Medicare Inpatient Wage Rate Assignment at Lehigh Valley Hospital, Allentown, Pennsylvania</i>	A-03-05-00003	April 2006
<i>Review of Controls to Report Wage Data at Citrus Memorial Hospital for the Period of October 1, 2002, Through September 30, 2003</i>	A-04-05-02003	April 2006
<i>Review of St. Joseph Hospital's Reported Fiscal Year 2004 Wage Data</i>	A-09-05-00040	April 2006
<i>Review of Riverside Medical Center's Reported Fiscal Year 2003 Wage Data</i>	A-05-05-00022	March 2006
<i>Review of Medicare Inpatient Wage Rate Assignment at Hackettstown Regional Medical Center, Hackettstown, New Jersey</i>	A-03-05-00005	March 2006
<i>Review of Day Kimball Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes</i>	A-01-05-00506	November 2005

Report Title	Report Number	Date Issued
<i>Review of Condell Medical Center's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes</i>	<u>A-05-05-00021</u>	August 2005
<i>Review of Hartford Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes</i>	<u>A-01-04-00524</u>	June 2005
<i>Review of Windham Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes</i>	<u>A-01-04-00511</u>	April 2005
<i>Review of Cape Cod Hospital's Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indices</i>	<u>A-01-04-00501</u>	November 2004



Lifespan

Delivering health with care.

September 20, 2019

225 Carolina Avenue
Providence, RI 02905

Department of Health and Human Services
Attn: Jeannette Gaughan, Sr. Auditor
Office of Audit Services Region 1
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Re: Report Number: A-01-17-00509

To Whom It May Concern:

Please find Rhode Island Hospital's (RIH) written comments for consideration in response to the U.S. Department of Health and Human Services, Office of Inspector General's (OIG) draft report No. A-01-17-00509, entitled *Rhode Island Hospital Submitted Some Inaccurate Wage Data*.

- Contract Labor Wages by \$16,387,450 and hours by 196,472

RIH does not agree with the OIG findings regarding how these hours should be calculated. As this has been calculated the same way going back to 1980 when Blue Cross of Rhode Island was the Medicare Intermediary and RIH has supplied this information the same way with no issue until this review. We believe that total hours, whether it was for Worksheet A-6 reclasses, A-8 offsets, or cost allocations on Worksheet B, has always been based on the average hours from their timesheets extrapolated to 52 weeks. The hours in a physician's contract state what is estimated to *be expected*, and not actual, based on the needs of the hospital. In addition, the hospital has numerous physicians in overhead departments- i.e. Department of Medicine/ Surgery, that must have their costs allocated on Worksheet B, Part 1. The only way this can be accomplished is by a B-1 statistic, which is the compilation of all the physicians' timesheets in those departments on a weighted-average basis, to use the percentage of time as the allocation statistic. This practice was also done in conjunction with the prior intermediary dating back to the 1980's.

- Employee salaries by \$14,715,652, and hours by 724,889

1. Non-Physician practitioner (NPP) costs incorrectly reported as part A \$9,090,245 151,399

RIH does not concur with the OIG's findings regarding non-physician practitioners. A previous agreement was reached with CMS on appeal of RIH's submission of the FY 1998 cost report. As part of that settlement, the hospital and CMS agreed that non-physician practitioners that do not bill for their services shall be considered Part A costs and be included as hospital allowable costs, and therefore included as such for calculations like the wage index. Since the settlement with CMS went into place, and as part of submitting the hospitals yearly cost report going forward; an adjustment is made on worksheet A-8 to offset the costs of all NPP's that bill for their services, while all others whose billing is done by the hospital remain as allowable costs. RIH has previously provided the OIG with the CMS agreement.

2. Salaries reported without hours

The hospital agrees that the hours associated with the dollars in question for payroll transfers were not compiled anywhere and therefore unable to have been captured. Since then, our system has been upgraded to be able to breakout the criteria for variable pay into distinct pay codes, which have helped eliminate the confusion between types of pay. The OIG also noted *“the hospital incorrectly reported salaries for variable pay (i.e. bonus or incentive pay) and payroll transfer amounts without associated hours.”* According to the Manual, section 4005.2, no hours are required for bonus pay along with any hours that cannot be determined will be reported under column 5. We believe that all the salaries in question were captured appropriately and, in most cases, did not include any additional hours (bonuses/incentive compensation)

3. Overstated hours 573,490

RIH is in concurrence with the OIG Findings and agrees that 573,490 hours were erroneously reported on line 1 which ultimately understated the hospitals average hourly wage by \$2.19. RIH has recently installed and is currently in the process of implementing a hospital wide system for tracking time studies, hours and wages more effectively. Phase 1 of implementation has recently begun, with future efforts to ensure contract labor data is processed and captured correctly are part of the ongoing efforts to streamline and more correctly capture wage-related costs and associated hours. This action plan is further explained below under *Additional Hospital Efforts*

- Home office wages by \$4,607,521

Rhode Island Hospital is in concurrence with the OIG findings and agrees that \$4,607,521 on line 14 of Worksheet S-3, part II should be subtracted from the total pooled home office salaries and was a result of an oversight in the calculations. Along with Lifespan Corporate Services, two other small affiliates included within the home office report were erroneously duplicated in the pooled amount. RIH has addressed this issue by correcting the formula in the workpaper setup to correctly calculate the pool of home office salaries, which no longer overstates certain expenses and pulls the correct allocation column onto the cost report. Cost report preparers have noted this occurrence and will review prior to submitting next year's cost report.

- Employee wage-related costs by \$2,001,247

RIH agrees with the OIG findings that the EAP program does not meet the requirements of a core wage-related cost, and therefore erroneously overstated the wage data by a total of \$2,001,247; in turn resulting in an overstated average hourly wage rate by \$0.20. Since this filed cost report, RIH has changed the pension cost calculation and is currently using current years' data. Cost report preparers were advised that any wage-related cost of the employee assistance program that does not meet the 1% threshold, along with other requirements are not allowable.

Additional Hospital Efforts to capture and produce more accurate Cost Report Data:

Process improvement for Cost Report data has been ongoing over the last several years to better capture cost report data, continued streamlining efforts to be more efficient in our reporting mechanisms and methodology and produce accurate data. Lifespan's recent efforts involve implementing a new automated system that replaces the manual efforts used to compile the physicians time studies. This new system includes internal controls to ensure that hours are reported as accurately as possible with oversight from administrative staff to monitor both completion and the content of the system. In addition, this system provides extensive reporting technology available to reimbursement staff, management, and other administrative personnel. With implementation currently underway, we at Lifespan believe that automating this process will enhance our compliance with cost report preparation going forward.

Sincerely,



Karen Reimels
Director, Corporate Financial Services

Cc:

Mary A. Wakefield, Executive Vice President and Chief Financial Officer

Donna Schneider, Vice President, Compliance and Internal Audit