

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ST. JOSEPH'S HOSPITAL AND
MEDICAL CENTER 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-01-17-00510

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 St. Joseph's Hospital and Medical Center (the Hospital), in Phoenix, Arizona, for this review because of its potential to significantly affect Medicare payments to many hospitals in its State in Federal Fiscal Year (FFY) 2019.

Because it applied to be considered a rural hospital for wage index purposes, the Hospital's wage data contributed to the Arizona rural wage index (RWI) for FFY 2019. Federal law does not allow urban hospitals to be assigned wage indexes lower than the RWI for their State. This is known as the "rural floor." Accordingly, the Hospital's wage data will affect FFY 2019 payments to Arizona hospitals receiving the RWI or the rural floor wage index.

Our objective was to determine whether the Hospital complied with Medicare requirements for reporting wage data to be 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.

St. Joseph's Hospital and Medical Center 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 \$12,338,804 and overstated its hours by 31,827. These errors occurred because the Hospital (1) reassigned the assembly and reporting of wage data to a new staff group, (2) did not have adequate review procedures to ensure that the correct dollars and hours were reported on the correct lines of the wage data worksheet, and (3) did not have adequate quality control over the entry of contract labor data into its accounting system.

Because OIG has no authority to correct wage data, we contacted CMS and then the Hospital's Medicare administrative contractor (MAC) with our findings and suggested corrections. The MAC, with CMS approval, made the corrections. If the data had not been corrected by the Hospital's MAC as a result of this review, it would have raised the rural wage index from 1.0528 to 1.0627. We estimated that, had it not been corrected, the overstatement of the rural wage index would have resulted in \$11.6 million in overpayments for inpatient stays at the 54 Arizona hospitals that will receive the rural wage index or the benefit of rural floor wage index in FFY 2019.

What OIG Recommends and St. Joseph's Hospital's Comments

We recommend that the Hospital (1) ensure that all personnel involved in the process are fully trained to comply with Medicare wage data reporting requirements, (2) annually review all software scripts and manual procedures to ensure compliance with Medicare wage data reporting requirements, and (3) implement more effective quality controls over the entry of contract labor data into its accounting system.

In written comments on our draft report, the Hospital concurred with our findings and recommendations and described the steps it has taken to ensure its cost reports are prepared accurately in compliance with Medicare requirements.

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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. Federal law requires that the area wage indexes applied to hospitals in urban areas of a State may not be less than the area wage index of hospitals located in rural areas in that State. This provision is known as the rural floor.

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 St. Joseph's Hospital and Medical Center (the Hospital), located in Phoenix, Arizona, for this review because of its potential to significantly affect Medicare payments in its State 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

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. 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.

Wage Data and Wage Indexes

CMS must annually adjust IPPS 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.¹

CMS determines a wage index by dividing the occupational-mix-adjusted average hourly wage (AHW) for acute-care hospitals in a geographic area by the national occupational-mix-adjusted AHW for acute-care hospitals. 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.²

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.

Urban Area Wage Indexes

CMS calculates wage indexes for the core-based statistical areas (CBSAs) designated by the Office of Management and Budget. In general, a CBSA consists of one or more counties (or equivalents) oriented around an urban center of 10,000 people or more, together with adjacent communities having a high degree of economic and social integration with that urban core.

Rural Wage Indexes and the Rural Floor

In addition to calculating wage indexes for urban-centered areas, CMS generally calculates a rural area wage index for each State, based on the wage data of the State's rural hospitals. The wage indexes applied to urban hospitals in a State cannot be lower than the rural area wage index for that State.³ This provision is called the rural floor.

¹ 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.

² 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.

³ The Balanced Budget Act of 1997, P.L. No. 105-33 § 4410.

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)).

Additionally, CMS must apply rural floor wage indexes in a manner that is budget neutral on a national level.⁴ Accordingly, to balance the increase in wage indexes for hospitals receiving the benefit of their States’ rural floors, CMS must lower wage indexes nationally by applying a rural floor budget neutrality factor.

Geographic and Urban-to-Rural Reclassifications and Wage Index Calculations

Under section 1886(d)(10) of the Act, a hospital may apply to the Medicare Geographic Classification Review Board (MGCRB) for reclassification from its geographical CBSA to another CBSA to receive a higher wage index, if it meets certain criteria related to AHW and proximity to the target CBSA. In this type of reclassification, the hospital reclassifies from an urban area to a different urban area.

Under section 1886(d)(8)(E) of the Act, a qualifying urban hospital may apply to CMS for rural status⁵ for Medicare payment purposes, including but not limited to contributing to and being assigned the relevant rural wage index.

A hospital may receive both an MGCRB (urban-to-urban) and an urban-to-rural reclassification and all related Medicare payment advantages.⁶ However, for the purposes of wage index calculation, CMS will not use an urban-to-rural hospital’s wage data in the calculation of the State’s rural wage index if the hospital also has an urban-to-urban reclassification. If a hospital with dual reclassifications wishes to contribute to the rural wage index, it can withdraw its MGCRB reclassification by a certain deadline, and CMS will then use its wage data to calculate the rural wage index.

⁴ Patient Protection and Affordable Care Act, P.L. No. 111-148 § 3141.

⁵ An IPPS hospital located in an urban area may be reclassified as rural if (1) it is located in a rural census tract, (2) it is deemed rural by any State law or regulation, or (3) it would meet all requirements of a rural referral center or a sole community hospital if it were located in a rural area (the Act, § 1886(d)(8)(E)).

⁶ Congress enacted the MGCRB reclassification process and the urban-to-rural reclassification process about a decade apart. Two court rulings (*Geisinger Community Medical Center v. Secretary*, 794 F.3d 383 (3rd Cir. 2015), and *Lawrence + Memorial Hospital v. Secretary*, 812 F.3d 257 (2nd Cir. 2016)) stated that CMS could not preclude hospitals from receiving an MGCRB reclassification in addition to an urban-to-rural reclassification. CMS’s current policy is to allow a hospital to obtain both reclassifications, in either order (that is, either MGCRB first or second).

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,⁷ 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 underpayments⁸ resulting from inaccurate wage data.

St. Joseph's Hospital and Medical Center

The Hospital, located in Phoenix, Arizona, is a 595-bed, not-for-profit hospital that provides a wide range of health, social, and support services. The Hospital is part of Dignity Health, one of the largest healthcare systems in the western United States, with more than 40 hospitals in Arizona, California, and Nevada.

The Hospital's FFY 2015 Medicare cost report covers the period from July 2015 through June 2016.⁹ We selected the Hospital for this review because of its potential to significantly affect Medicare payments in its State in 2019. When we began this review partway through the FFY 2019 wage index development process, the Hospital had dual MGCRB (Phoenix to Prescott) and urban-to-rural reclassifications. During our review, the Hospital withdrew its MGCRB reclassification by the stated deadline. Accordingly, CMS used the Hospital's wage data to calculate the Arizona rural wage index for FFY 2019.

⁷ 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 Federal fiscal year (42 CFR § 412.64(k)).

⁸ 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").

⁹ 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 July 1, St. Joseph's Hospital's FFY 2015 cost report covers the period of July 1, 2015, through June 30, 2016.

HOW WE CONDUCTED THIS REVIEW

Our audit covered the \$554 million in wages and wage-related costs and 10.6 million 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 FY 2015 Medicare cost report. As a result, the Hospital overstated its occupational-mix-adjusted Part A wages and wage-related costs by \$12,338,804 and overstated Part A hours¹⁰ by 31,827. Specifically, the Hospital overstated:

- employee salaries by \$8,366,649 and hours by 21,980,
- home office wages and wage-related costs by \$2,356,524,
- employee wage-related costs by \$1,461,613, and
- contract labor wages by \$154,018 and hours by 9,847.

These errors occurred because of a combination of factors. The Hospital and Dignity Health noted that, for the year in question, responsibility for assembling and reporting wage data had been shifted from the hospitals' regional offices to the central corporate office. In addition, the review of the software scripts and manual procedures used to extract wage data from the financial systems was not adequate to ensure that the results of those scripts and procedures met the requirements of the CMS *Provider Reimbursement Manual* (the Manual) (that is, the review procedures did not ensure that the correct dollars and hours were reported on the

¹⁰ "Part A wages" refers to the numerator in the average hourly wage calculation for an individual hospital or a CBSA 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.

correct lines of the wage data worksheet). Finally, there was inadequate quality control over the entry of contract labor data into the Hospital's accounts payable system.

As a result of this this review, the Hospital's MAC corrected the inaccurate wage data. If the MAC did not correct the wage data, the Hospital's occupational-mix-adjusted average hourly wage would have been increased from \$46.85 to \$48.31, an overstatement of \$1.46, or approximately 3 percent, and the inaccurate wage data would have raised the rural wage index from 1.0528 to 1.0627. We estimated that the overstatement of the rural wage index would have resulted in \$11.6 million in overpayments to 54 Arizona hospitals (9 rural hospitals and 45 urban hospitals receiving the benefit of the rural floor) had it not been corrected (see Appendix C for our estimation methodology). Because of budget neutrality on a nation-wide level, overpayments to Arizona hospitals would have resulted in underpayments to hospitals in other States.

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).¹¹ Additionally, 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 (Worksheets S-3, parts II, III, and IV of the Medicare cost report).

EMPLOYEE SALARIES AND HOURS

The Hospital did not comply with the Manual's instructions for reporting salaries and hours. Specifically, the Hospital:

- did not report Part A teaching salaries and hours on the appropriate line,
- did not report nonphysician practitioners' salaries and hours on the appropriate line as Part B salaries and hours, and

¹¹ "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)).

- reported physicians, interns and residents, and certain home office personnel¹² on the correct lines but reported erroneous salaries and hours for these categories because of errors made when extracting data from the general ledger or payroll system.

The combined effect of these errors was to overstate the Hospital's occupational-mix-adjusted Part A wages by \$8,366,649 and hours by 21,980. This would have overstated the Hospital's occupational-mix-adjusted average hourly wage by \$0.99, if not corrected.

HOME OFFICE WAGES AND WAGE-RELATED COSTS

Error in Executing Allocation Methods

When completing its Home Office Cost Statement, a chain organization should first directly assign costs to components whenever possible, 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 Manual § 3902). The purpose of the order of these methods is to make allocations as accurate as possible.

When performing its home office allocation, Dignity Health directly assigned corporate officers' wages and wage-related costs to hospitals. However, Dignity Health subtracted only a portion of those officers' costs from the residual pool that was later allocated on the basis of total costs. Therefore, that allocation pool was overstated and hospitals' individual shares of the pool were overstated.

Errors Relating to Defined Benefit Plan Costs

A hospital may report its proper share of the defined benefit plan costs (pension costs) for home office personnel on the appropriate line of Worksheet S-3, part II. Pension costs are allowable only to the extent of annual cash-basis contributions averaged over a 3-year period (the Manual § 4005.4). A hospital should not report its share of general ledger pension expense for the wage data reporting period, because that is not an allowable wage-related cost.

When determining the pool of home office costs to be allocated, Dignity Health included unallowable general ledger pension expense. This overstated home office wage-related costs. Dignity Health also allocated allowable home office pension costs to its hospitals, but it allocated them to the Worksheet S-3, part II, lines for hospital employees rather than to the line for home office personnel. This overstated costs for hospital employees and understated home office personnel costs.

¹² This refers to the home office personnel reported on line 8 of the FFY 2015 Worksheet S-3, part II, which is for the salaries and hours of home office personnel who were also included in the Hospital's total salaries and hours on line 1.

Combined Effect of Home Office Errors

The combined effect of the errors in the allocation pool and reporting home office personnel costs on the wrong lines was to overstate the Hospital's occupational-mix-adjusted Part A wages by \$2,356,524. This would have overstated the Hospital's occupational-mix-adjusted average hourly wage by \$0.32, if not corrected.

EMPLOYEE WAGE-RELATED COSTS

Disallowed Wage-Related Costs

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). Employee health insurance and health-related services is an example of a core wage-related cost. The Manual describes health-related services as inpatient and outpatient health services that are not covered under a hospital's health insurance plan but are provided to employees at no cost or at a discount. Examples include employee physicals, flu shots, and smoking cessation and weight control programs.

The Hospital reported \$282,059 in employee assistance program (EAP) costs in core wage-related costs, categorizing EAP under health-related services. The Hospital did not provide us with documentation that the EAP provided the type of health-related services described by the Manual, as opposed to, for example, legal or financial advice or assistance with finding eldercare (services provided by some EAPs). Because the Hospital did not provide documentation for the EAP, we requested that the MAC remove the \$282,059 from the Hospital's core-wage related costs.

Errors in Allocating Wage-Related Costs

The Manual's instructions required the Hospital to allocate the core wage-related costs reported on Worksheet S-3, part IV, to the appropriate lines on Worksheet S-3, part II. To do this, it allocated some costs by salaries and other costs by hours. Accordingly, the Hospital's errors in reporting salaries and hours (described above) caused errors in its allocation of core wage-related costs. Additionally, when the Hospital calculated the allocation percentages for wage-related costs based on total salaries and total hours, it included the salaries and hours for some home office personnel who should not have been included in the calculation because their wage-related costs are allocated in a separate process.

Combined Effect of Employee Wage-Related Costs Findings

The combined effect of the Hospital reporting \$282,059 in disallowed EAP costs and allocating wage-related costs based on incorrect salaries and hours was to overstate the Hospital's

occupational-mix-adjusted Part A wages by \$1,461,613. This would have overstated the Hospital's occupational-mix-adjusted average hourly wage by \$0.20, if not corrected.

CONTRACT LABOR WAGES AND HOURS

The Hospital used its accounts payable system to track wages and hours for all contract labor lines. For some invoices, the Hospital recorded wages without associated hours or hours without associated dollar amounts. The Hospital also made some duplication and reversal errors.

The combined effect of these errors was to overstate the Hospital's occupational-mix adjusted Part A wages by \$154,018 and hours by 9,847. This would have understated the Hospital's occupational-mix-adjusted average hourly wage by \$0.04, if not corrected.

CAUSES OF ERRORS

These errors occurred because of a combination of factors. The Hospital and Dignity Health noted that, for the year in question, the workflow had been reorganized within the cost reporting team. In addition, the review of the software scripts and manual procedures used to extract wage data from the financial systems was not adequate to ensure that the results of those scripts and procedures met the requirements of the Manual (that is, the review procedures did not ensure that the correct dollars and hours were reported on the correct lines of the wage data worksheet). Finally, there was inadequate quality control over the entry of contract labor data into the Hospital's accounts payable system.

ESTIMATED EFFECT ON IPPS PAYMENTS TO HOSPITALS

Had the MAC not corrected the Hospital's wage data as a result of this review, the Hospital's occupational-mix-adjusted average hourly wage would have been increased from \$46.85 to \$48.31, an overstatement of \$1.46,¹³ or approximately 3 percent. If the data had not been corrected, it would have raised the rural wage index from 1.0528 to 1.0627. We estimated that the overstatement of the rural wage index would have resulted in \$11.6 million in overpayments to 54 Arizona hospitals (9 rural hospitals and 45 urban hospitals receiving the benefit of the rural floor), had it not been corrected. Because of budget neutrality on a nationwide level, overpayments to Arizona hospitals would have resulted in underpayments to hospitals in other States.

¹³ The sum of the effects of the four findings is \$1.47 (\$0.99 + \$0.32 + \$0.20 - \$0.04). The difference of \$0.01 between \$1.47 and \$1.46 is a rounding-related difference.

RECOMMENDATIONS

We recommend that the Hospital:

- ensure that all personnel involved in Medicare wage data reporting are fully trained in compliance with the requirements of the Manual,
- review all software scripts and manual procedures annually to ensure that the scripts and procedures result in wage data that meet the requirements of the Manual, and
- implement more effective quality controls over the entry of contract labor data into the accounts payable system.

ST. JOSEPH'S HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Dignity Health, on behalf of the Hospital, concurred with our findings and recommendations and described the steps it has taken to ensure that the Hospital's cost reports are prepared accurately in compliance with Medicare requirements. Dignity Health disagreed with one element in the cause section of our draft report. We, therefore, have updated the cause section in the final report on the basis of the Dignity Health's comments.

Dignity Health's comments on behalf of the Hospital are included in their entirety as Appendix D.

OTHER MATTERS

APPROVAL NEEDED FOR ALTERNATIVE METHODOLOGY FOR REPORTING SOME SALARY COSTS

According to section 4005.2 of the Manual, the proper source for salaries and wages reported in the wage data is the general ledger, and the proper source for hours is the payroll report. The Manual further states that although this is CMS's recommended methodology, it does not preclude using a different approach if it would produce a more accurate finding for the purposes of the wage index. However, a hospital must obtain approval from its MAC to use a different methodology.

The Hospital reported salaries for physicians, nonphysician practitioners, interns, and residents using the payroll report, rather than a general ledger report, because the general ledger system did not have accounts specifically for physician and nonphysician practitioner paid time off. For this year, using the payroll report produced more accurate results than using the general ledger would have. However, the Hospital should obtain approval from its MAC before using this methodology in the future. The Hospital could also consider adjusting its general ledger system to track paid time off for physicians and nonphysician practitioners.

RELIANCE ON THE POOLING METHOD OF ALLOCATION FOR HOME OFFICE WAGE COSTS

According section 3902 of the Manual, when completing its Home Office Cost Statement (HOCS), 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.

Dignity Health and the Hospital used different allocation methodologies to complete the HOCS and to complete the home office wages and wage-related costs line of the Hospital's wage data. On the HOCS, 39 percent of the Hospital's total home office costs was directly assigned, 43 percent was functionally allocated, and the remaining 18 percent was allocated by pooling. For the wage data, 7 percent of home offices wages and wage-related costs was directly assigned and 93 percent was allocated by pooling.

Although pooling is an acceptable allocation methodology, it is the least preferred method according to the Manual. Additionally, it is does not appear to be logical to use different allocation methodologies for the HOCS and for hospitals' home office wage data, if the shared goal for both documents is the most accurate allocation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the \$554 million in wages and wage-related costs and 10.6 million 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, Dignity Health, 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 Dignity Health 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;
- discussed our findings with Hospital officials and provided suggested wage data corrections to the Hospital's MAC; and
- estimated the overpayments to Arizona hospitals that were prevented by the MAC correcting the errors in the Hospital's wage data as a result of our input.

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>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 Indexes¹⁴</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

¹⁴ 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

APPENDIX C: ESTIMATION METHODOLOGY

To estimate for informational purposes in this report the overpayments to Arizona hospitals that were prevented by correction of the errors we found, we used the following methodology:

1. As an approximation of what each hospital's number of Medicare discharges will be in FFY 2019, for most hospitals we used the number of Medicare discharges reported on their Medicare cost reports for their fiscal years beginning in FFY 2017. For the 11 hospitals with later-starting fiscal years, which had not submitted their FFY 2017 cost reports at the time of our writing, we used data from their cost reports for fiscal years beginning in FFY 2016. We excluded any hospitals which had closed after submitting their most recent cost report.
2. We used each hospital's transfer-adjusted case mix index (Version 36) as an approximation of what its aggregate Medicare claim diagnosis-related groups will be in FFY 2019.
3. We calculated what the Arizona rural wage index would have been with the Hospital's uncorrected wage data.
4. We then estimated FFY 2019 payments to the hospitals receiving the rural wage index or rural floor wage index using (1) the final 2019 wage index calculated by CMS and (2) the wage index we calculated using the Hospital's uncorrected wage data. We used the following formulas:

$$\begin{aligned} &(((\text{Labor Share of Standard Operating Payment} * \text{Wage Index}) + \text{Non-Labor Share of} \\ &\text{Standard Operating Payment}) * \text{Transfer-Adjusted Case Mix Index} + (\text{Standard Capital} \\ &\text{Payment} * \text{Geographic Adjustment Factor} * \text{Transfer-Adjusted Case Mix Index})) * \text{Number of} \\ &\text{Medicare Discharges} = \text{Individual Hospital's Estimated FY 2019 Payments} \end{aligned}$$

Note: By law, the geographic adjustment factor is the wage index raised to the power of .6848.

We estimated only the operating and capital base payments and did not include in the estimation process additional payments such as those for indirect medical education. We used the standardized payment amounts for hospitals that submitted quality data and were meaningful users of electronic health records.

5. We subtracted the total payments calculated using the final 2019 wage index calculated by CMS from the total payments calculated using the wage index we created using the Hospital's uncorrected wage data. The difference of \$11.6 million is our estimate of overpayments to Arizona hospitals prevented by the correction of the errors we found. Because of budget neutrality, overpayments to Arizona hospitals would have resulted in underpayments to hospitals in other States.

APPENDIX D: ST. JOSEPH'S HOSPITAL COMMENTS



185 Berry Street, Suite 300
San Francisco, CA 94107
direct 415.438.5500
fax 415.591.5727
dignityhealth.org

March 15, 2019

Mr. David G Lamir
Regional Inspector General for Audit Services
Office of Audit Services, Region I
JFK Federal Building, Room 2425
Boston, MA 02203

RE: Draft Report Number: A-01-17-00510
St. Joseph Hospital and Medical Center

Mr. Lamir,

We are responding to the draft report entitled "St. Joseph Hospital and Medical Center Submitted Some Inaccurate Wage Data" (Report). We appreciate the opportunity to respond to the findings and recommendations identified in the Report.

St. Joseph Hospital and Medical Center (Hospital) strives to ensure that its Medicare cost reports are prepared accurately and in compliance with the applicable Federal and State rules and regulations. As part of the Hospital's compliance efforts, policies and procedures addressing the preparation and review of cost reports were implemented over fifteen years ago. These policies and procedures are regularly updated to address changes in applicable regulations as well as process improvements. In addition, employees involved in the preparation and review of the cost report receive ongoing training regarding Medicare requirements for reporting wage data used by the Centers of Medicare and Medicaid Services (CMS) to calculate wage index, and internal policies and procedures. Finally, enhanced preparation tools are available to ensure cost reports are prepared in a consistent and auditable manner, and help streamline the review process.

The continued focus on accuracy and compliance with CMS requirements has led to other organizational changes. Specifically, the preparation and review of the cost report was assigned to a consolidated and dedicated staff with expertise in cost reporting requirements. In addition, the cost report goes through several levels of reviews, including a review by a Reimbursement Manager, a Reimbursement Director, and ultimately the hospital Chief Financial Officer. As needed, experienced third party reviewers are also utilized to perform additional reviews. Indeed nationally recognized

experts have been engaged to both train employees and review specifically the area of wage index and occupational mix reporting.

Notwithstanding these efforts, the Report identified errors, with which the Hospital concurs. The Report listed the shifting of cost report responsibilities from regional staff to the central corporate office as a cause of some of the errors identified. This is inaccurate. There was not a shift as described in this report. Instead, the workflow was reorganized amongst the team, and that workflow change currently allows for an additional set of reviews.

In the Report, the OIG recommends the Hospital implement review and reconciliation procedures to ensure that the wage data it reports in the future is in compliance with Medicare requirements. Below is a description of the review and reconciliation procedures implemented by the Hospital to address each finding:

Employee Salaries and Hours

The Hospital concurs that the filed Medicare cost report did not report Part A teaching and non-physician practitioners' salaries and hours on the appropriate line. The Hospital also concurs that errors were made when extracting data for hospital system data files. However, the Hospital did identify these issues during a post-filing review and requested the MAC to make the appropriate revisions to the filed Medicare cost report based on the CMS wage index development timetable. The Hospital does employ an extensive wage index preparation and review process. The pre-file review will be updated to ensure this item is identified earlier in the preparation process.

Home Office Wages and Wage-Related Costs

The Hospital concurs with these findings related to the allocation methods and defined benefit plan costs. Dignity Health has updated its preparation and review processes for subsequent periods, providing for more transparency and greater understanding of the home office costs included on each hospital cost report.

Employee Wage-Related Costs

The Hospital believes that the Employee Assistance Program (EAP) is an employee benefit that provides all employees health-related services. However, the Hospital recognizes it could not provide adequate supporting documentation for the program. At this time, the Hospital concurs with the adjustment and will forgo claiming EAP as a wage-related cost in future cost report filings.

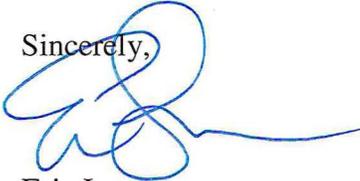
The Hospital concurs with the error in which it allocates wage-related costs. This allocation will be corrected for subsequent cost report filings.

Contract Labor Wages and Hours

The Hospital concurs with this finding in regards to contract labor wages without associated hours or hours without associated dollar amounts. The Hospital utilizes data from the accounts payment system to review contract labor costs and hours. The Hospital will team with the Accounts Payable department to strategize on how to improve the quality of the contract labor dollars and hours that is entered into the accounts payable system.

Thank you for this opportunity to respond to your audit findings and recommendations. Should you have any additional questions, please contact me at (415) 438-5752 or Kenton Fong at (916) 631-3612.

Sincerely,



Eric Lucas
Vice President, Government Programs
Dignity Health