Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NANTUCKET COTTAGE HOSPITAL DID NOT ACCURATELY REPORT CERTAIN WAGE DATA, RESULTING IN OVERPAYMENTS TO MASSACHUSETTS HOSPITALS

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

March 2017
A-01-15-00502

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at https://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Nantucket Cottage Hospital overstated its 2011 Medicare wage data. As a result, in 2015 Medicare overpaid the Hospital an estimated $156,000 and overpaid 55 other hospitals in the State an estimated total of $133.6 million.

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. CMS uses the wage data to calculate acute-care hospital wage indexes, which measure geographic area labor market costs 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 also 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 have found that hospitals often reported inaccurate wage data, which resulted in increased Medicare payments in their designated geographic area. We selected Nantucket Cottage Hospital (the Hospital) because its fiscal year (FY) 2011 wage data set the rural floor wage index for Massachusetts for 2015.

The objective of this review was to determine whether the Hospital complied with Medicare requirements for reporting wage data in its FY 2011 Medicare cost report.

BACKGROUND

The geographic designation of a hospital influences its Medicare payments. Under both the inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) for hospitals, CMS adjusts payments through wage indexes to reflect labor cost variations among localities. For 2014, Medicare made more than $112 billion in IPPS payments and $41.1 billion in OPPS payments to hospitals.

CMS uses the Office of Management and Budget core-based statistical areas (CBSAs) to identify labor markets. CMS calculates a wage index for each CBSA and a statewide rural wage index for each State. CMS may not assign a hospital a wage index lower than the State's rural wage index. Section 3141 of the Affordable Care Act requires that CMS apply this rural floor in a manner that is budget neutral on a national level. 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.

WHAT WE FOUND

The Hospital did not always comply with Medicare requirements for reporting wage data in its FY 2011 Medicare cost report. As a result, the Hospital overstated wages and wage-related costs by $232,365 (net) and understated hours by 18,060 (net). This affected both the numerator and denominator of its average hourly wage calculation. Specifically, the Hospital:

- overstated wage-related costs by $434,907,
- understated home office wages by $290,435 and hours by 15,943,
- overstated salaries by $26,973 and understated hours by 2,138, and
- overstated contract labor wages by $60,920 and hours by 21.

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

The incorrect wage data increased the Hospital's occupational mix adjusted average hourly wage from $49.0523 to $52.9095 and increased the Hospital's wage index from 1.2363 to 1.3336, overstatements of approximately 7.3 percent. As a result of the cost reporting errors, we estimated that Medicare overpaid the Hospital a total of $156,131 for FY 2015 inpatient services and calendar year (CY) 2015 outpatient services. We also estimated that Medicare overpaid 55 other hospitals in the State a total of $133.6 million for FY 2015 inpatient services and CY 2015 outpatient services because the Hospital's wage data set the rural floor wage index for Massachusetts. Because of the rural floor budget neutrality provision in section 3141 of the Affordable Care Act, the overpayments to Massachusetts hospitals caused underpayments to hospitals in other States. We did not estimate the total underpayments to hospitals in other States.

Because of the prospective nature of IPPS and OPPS, CMS has no mechanism to recover overpayments or remedy underpayments resulting from inaccurate wage data.

WHAT WE RECOMMEND

We recommend that the Hospital:

- ensure that all personnel involved in Medicare cost report preparation follow the requirements in the *Provider Reimbursement 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.

NANTUCKET COTTAGE HOSPITAL COMMENTS AND OUR RESPONSE

In written comments on our draft report, Partners HealthCare, responding on behalf of the Hospital, stated that the Hospital did not concur with our findings regarding unallowable housing costs and underreported home office costs and hours. The Hospital asserted that its personnel interpreted and followed the *Provider Reimbursement Manual* correctly. The Hospital concurred with our finding regarding salaries incorrectly reported as other wage-related costs.

The Hospital concurred with our findings regarding severance pay reported without hours, typographical errors in physician salaries and contract labor wages, and some unallowable contract labor travel costs.

The Hospital "strongly" objected to our reporting the effect of the Hospital's errors on other hospitals in Massachusetts.

We disagree with the Hospital's assertions and, for reasons we explain in more detail in the report, we maintain that our findings and recommendations are valid and that it is appropriate for us to report on the effect of the Hospital's errors to the fullest extent we can.

TABLE OF CONTENTS

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 costs 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 also 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."

Because of the prospective nature of current payment systems, CMS has no mechanism to retroactively adjust final wage indexes and recover overpayments (or remedy underpayments) resulting from inaccurate wage data. Accordingly, it is essential for hospitals to submit accurate wage data to ensure appropriate payments.

Our prior reviews, listed in Appendix A, have found that hospitals often reported inaccurate wage data, which resulted in increased Medicare payments in their designated geographic areas. CMS officials requested that we again conduct acute-care hospital wage index reviews, prompted by their concern about unusually high wage indexes, particularly in New England and California. This report is one in a series of wage index reviews of acute-care hospitals in New England and California.

We selected Nantucket Cottage Hospital (the Hospital) because its fiscal year (FY) 2011 wage data set the rural floor wage index for Massachusetts for 2015.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for reporting wage data in its FY 2011 Medicare cost report.

BACKGROUND

Medicare Inpatient and Outpatient Prospective Payment Systems

The geographic designation of a hospital influences its Medicare payments.

Under the inpatient prospective payment system (IPPS) for hospitals, Medicare pays hospitals predetermined, diagnosis-related rates for patient discharges. CMS uses a hospital's area wage index to adjust the IPPS payment rates to reflect labor cost variations among localities. IPPS payment rates are set for the Federal FY, using data from 4 FYs prior (for example, FY 2011 data were used to set FY 2015 IPPS payment rates).

Under the outpatient prospective payment system (OPPS) for hospitals, Medicare pays hospitals for individual services. CMS uses a hospital's area wage index to adjust the labor-related share of the payment for each service to reflect the local labor market.[1] OPPS payment rates are set for the calendar year (CY), using data from 4 FYs prior (for example, FY 2011 data were used to set CY 2015 OPPS payment rates).

Medicare made more than $112 billion in IPPS FY 2014 payments and $41.1 billion in OPPS CY 2014 payments to hospitals.[2]

Wage Indexes

CMS uses the Office of Management and Budget core-based statistical areas (CBSAs) to identify labor markets and to calculate and assign wage indexes to hospitals. CMS calculates a wage index for each CBSA and a statewide rural wage index for each State. The wage index for each CBSA and statewide rural area is based on the average hourly wage of the hospitals in those areas, adjusted by occupational mix,[3] divided by the national average hourly wage. Additionally, Federal law requires that the hospitals in urban CBSAs not be assigned a wage index less than the State's rural wage index.[4] This provision is known as the "rural floor."

To calculate wage indexes, CMS uses hospital wage data collected 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). A hospital's average hourly wage is calculated by dividing total dollars (numerator) by total hours (denominator). Arriving at the final numerator and denominator in this rate computation involves a series of calculations. Inaccuracies in either the dollar amounts or hours reported could have a substantial effect on the final rate computation.

Section 1886(d)(3)(E) of the Social Security Act (the Act) requires that CMS update wage indexes annually in a manner that ensures that aggregate national payments to hospitals are not affected by changes in the indexes (i.e., in a manner that is "budget neutral"). Hospitals must accurately report wage data for CMS to determine the accurate distribution of payments. Further, section 1886(d)(3)(A)(iv) of the Act requires CMS to update labor and nonlabor average standardized amounts by the percentage increase in the market basket index, which measures the

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

[2] Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2016, chart 6-15, p. 81, and chart 7-9, p. 109.

[3] 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 costs of labor.

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

way in which price changes affect hospital costs. The inclusion of unallowable costs in wage data could produce an inaccurate market basket index for updating prospective payments to hospitals.

Section 3141 of the Affordable Care Act[5] requires that CMS apply rural floor wage indexes in a manner that is budget neutral on a national level. 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. In FY 2015, hospitals (including those not benefiting from the rural floor) had their wage indexes lowered by approximately 1 percent to maintain national budget neutrality with respect to the rural floor. Inaccuracies in wage data reporting by rural hospitals could have a substantial effect on the computation of the rural floor budget neutrality factor.

No Mechanism to Correct Payments Calculated Based on Inaccurate Wage Data

As stated above, the IPPS and OPPS are both prospective payment systems. A prospective payment system is a method of reimbursement in which payment is made based on a predetermined, fixed amount. CMS's development of annual wage indexes is part of establishing predetermined rates to be used for the prospective payment system. During wage index development, a process which lasts longer than a year, hospitals, MACs, and CMS have the opportunity to identify and correct inaccurate wage data, in order that inaccurate data not be used to calculate wage indexes. CMS sets deadlines for correction requests during the wage index development process.

Except in certain very limited circumstances, if inaccurate wage data are not identified by the specified deadlines, the data will be used by CMS to calculate Medicare payments for the payment year.[6] We refer to payments calculated based on inaccurate wage data as "overpayments" or "underpayments" in this report, even though we are referring to improper payments caused by incorrect rates rather than caused by questionable claims submission or claims processing that such terms typically describe. It is because of the prospective, predetermined nature of prospective payment system that CMS does not have such a mechanism to retroactively adjust payments made based on inaccurate wage data.

Nantucket Cottage Hospital

The Hospital is a 19-bed acute-care hospital located on Nantucket Island, 30 miles off the coast of Massachusetts. In 2006, Nantucket Cottage Hospital became an affiliate of Massachusetts General Hospital, a member of Partners HealthCare (Partners).

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

[6] CMS will correct an individual hospital's wage index during the payment year and apply the corrected wage index prospectively (i.e., for the remainder of the year); 42 CFR § 412.64(k) specifies that CMS may make a midyear correction to a hospital's wage index only if the hospital can show that its MAC or CMS made an error in tabulating its data and that the hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal FY.

For FY 2015, the Hospital was one of only two Massachusetts hospitals geographically located in rural areas. However, because of the application of Federal law, only Nantucket Cottage Hospital's wage data determined the rural floor wage index for the State for FY 2015.[7]

The Hospital's FY 2011 Medicare cost report covered the period October 1, 2010, through September 30, 2011.

Federal Requirements for Reporting Hospital Cost Data

Federal regulations (42 CFR §§ 412.52 and 413.24) 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).[8] Additionally, chapter 40 of the CMS *Provider Reimbursement Manual* (the Manual) contains specific instructions for completing the Medicare cost report, Form CMS 2552-10.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $20,919,480 in wages and wage-related costs and 360,352 in hours for employees, home office staff, and contractors that the Hospital reported to CMS on its FY 2011 Medicare cost report. We evaluated compliance with selected Medicare cost reporting requirements. We limited our review of the Hospital's internal controls to those related to accumulating and reporting wage data for its FY 2011 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 B contains the details of our audit scope and methodology.

[7] CMS explained why it reclassified the other hospital from "rural" to "urban" in the August 22, 2014, edition of the Federal Register (79 Fed. Reg. 49853, 50370-50372).

[8] "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 reimbursable 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)). Federal regulations further state, "The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended" (42 CFR § 413.24(c)).

FINDINGS

The Hospital did not always comply with Medicare requirements for reporting wage data in its FY 2011 Medicare cost report. As a result, the Hospital overstated wages and wage-related costs by $232,365 (net) and understated hours by 18,060 (net). This affected both the numerator and denominator of its average hourly wage calculation. Specifically, the Hospital:

- overstated wage-related costs by $434,907,
- understated home office wages by $290,435 and hours by 15,943,
- overstated salaries by $26,973 and understated hours by 2,138, and
- overstated contract labor wages by $60,920 and hours by 21.

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

The incorrect wage data increased the Hospital's occupational mix adjusted average hourly wage from $49.0523 to $52.9095 and increased the Hospital's wage index from 1.2363 to 1.3336, overstatements of approximately 7.3 percent. As a result of the cost reporting errors, we estimated that Medicare overpaid the Hospital a total of $156,131 for FY 2015 inpatient services and CY 2015 outpatient services. We also estimated that Medicare overpaid 55 other hospitals in the State a total of $133.6 million for FY 2015 inpatient services and CY 2015 outpatient services because the Hospital's wage data set the rural floor wage index for Massachusetts. Because of the rural floor budget neutrality provision in section 3141 of the Affordable Care Act, the overpayments to Massachusetts hospitals caused underpayments to hospitals in other States. We did not estimate the total underpayments to hospitals in other States.

ERRORS IN REPORTED WAGE DATA

Wage-Related Costs

CMS introduced its reporting methodology for "wage-related costs" in 1994. CMS retains a list of core wage-related costs meant to include all commonly recognized fringe benefits that contribute significantly to the wage costs of a hospital and that are readily identifiable in the hospital records (currently, the list is lines 1 through 23 of Worksheet S-3, Part IV, of the Medicare Cost Report). Employee health insurance is an example of a core wage-related cost. Because CMS was concerned that individual hospitals might incur large wage-related costs not reflected on the core list, it also allowed hospitals to report fringe benefits not listed in the core list as other (i.e., non-core) wage-related costs, as long as those fringe benefits met the requirements set forth in the Manual. The current Manual, sections 4005.2 and 4005.4, sets forth the requirements for other wage-related costs reported in the wage data (Worksheet S-3, Parts II, III, and IV).

Unallowable Wage-Related Cost: Employee Housing

Employer-provided housing is not on the CMS list of core wage-related costs; therefore, to be reported as a wage-related cost it must meet the requirements for other wage-related costs. The Manual states that an other wage-related cost must be a fringe benefit as defined by the Internal Revenue Service (IRS) and, where required, must have been reported to IRS as wages. According to IRS Publication 15-B (*Employer's Tax Guide to Fringe Benefits*), a fringe benefit is a form of pay for the performance of services. IRS recognizes the fair market value (FMV) of housing (lodging) provided to employees or contractors as a fringe benefit.

The Hospital reported $192,224 in "cost of housing" employees, including corporate home office employees, as an other wage-related cost.[9] It explained that the term "cost of housing" referred to unrecovered employee housing costs (the actual cost less rental income).[10] The cost of housing employees was unallowable as an other wage-related cost because the cost to the employer of providing the housing is not an IRS-recognized fringe benefit[11] and, therefore, does not meet the Manual's requirements to be considered an other wage-related cost. Only the fair market value of the housing provided (less rents paid by the employees to the Hospital) is recognized by IRS as a fringe benefit.[12]

The Hospital explained its rationale for reporting "cost of housing" as a wage-related cost as follows: "Given that the cost report is a report of costs, the Hospital reported the cost of the worker housing it provided." The Manual states that only costs that are IRS-recognized fringe benefits may be reported as other wage-related costs in wage data (Worksheet S-3, Parts II, III, and IV), if they meet all requirements set forth in sections 4005.2 and 4005.4 of the Manual. Costs not meeting these requirements may be eligible for reporting elsewhere in the Medicare cost report for reimbursement purposes, but should not be reported in wage data as other wage-related costs for wage index purposes.

In discussions with the Hospital, we noted that the FMV of housing provided to employees, less rents paid to the Hospital, could have been reported as an other wage-related cost, if it had been reported to IRS as income to the employees. The Hospital stated that employees to whom it

[9] The housing was either owned by the hospital and rented to certain hospital employees or leased by the hospital and subleased to certain hospital employees.

[10] The scope of this review did not include determining whether the "cost of housing" employees, as reported by the Hospital, was accurate or reasonable.

[11] We confirmed our understanding of the law with IRS.

[12] As stated above, IRS defines fringe benefits as a form of payment for services. An employee cannot be "paid" with the employer's costs; the employee is paid with the value of the housing received. For this same reason, the cost to the employer of providing housing also does not meet the Medicare definition of a fringe benefit. The Manual, section 2144.1, defines fringe benefits as "amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee, his/her dependent (as defined by IRS), or his/her beneficiary derives a personal benefit before or after the employee's retirement or death." An employee who receives housing is paid the value of the housing, not the cost to the employer.

had provided housing had paid FMV rent to the Hospital for the housing,[13] and accordingly, the Hospital reported no additional income to IRS for those employees.[14] Therefore, the Hospital has no allowable employee housing to report as an other wage-related cost, because the net value (FMV less rents paid) was $0.

Unallowable Wage-Related Cost: Housing for Temporary Employment Agency Personnel

Section 4005.2 of the Manual instructs hospitals to report on lines 11, 28, 33, and/or 35 of Worksheet S-3, Part II, amounts paid for services furnished under contract. Section 4005.2 also specifies that the amounts reported on these lines should not include travel expenses.

CMS allows hospitals to report wage-related costs for contractors on the contract labor lines. Housing is not on the CMS list of core wage-related costs; therefore, to be reported as a wage-related cost it must meet the requirements for other wage-related costs. CMS applies the same criteria to other wage-related costs reported for contractors as it does to other wage-related costs reported for employees. In addition to other requirements, the CMS criteria state that an other wage-related cost must be a fringe benefit as defined by IRS and, where required, must have been reported as wages to IRS. IRS recognizes the FMV of lodging provided to employees and contractors as a fringe benefit.

On contract labor lines 11 and 28, the Hospital reported $356,427 in "cost of housing" provided to workers furnished by temporary personnel agencies with which the Hospital had contracted.[15,16] The $356,427 in "cost of housing" temporary agency personnel was unallowable as contract labor for two reasons. First, the cost to the Hospital of providing the housing did not represent an amount paid for services furnished under contract. Second, the cost to the Hospital of providing the housing (as opposed to the FMV of the housing) is not an IRS-recognized fringe benefit and, therefore, does not meet the Manual's requirements to be considered an other wage-related cost. Because the "cost of housing" was neither an amount paid for contract services nor an other wage-related cost for contract laborers, it should not have been reported on the contract labor lines of Worksheet S-3, Part II.

[13] To recap and summarize, the Hospital stated that employees paid the Hospital FMV for housing, but the Hospital's cost to provide the housing exceeded that FMV by $192,224. The Hospital reported this $192,224 "net cost" (cost minus FMV) as an other wage-related cost.

[14] The scope of this review does not include determining whether the Hospital's valuations were accurate or reasonable. The Hospital explained that for employees receiving short-term housing (mostly physicians and physician assistants), it had determined the FMV of a two-bedroom apartment to be $72.50 per day for CY 2010 and $60.86 per day for CY 2011. The Hospital explained that for the two employees receiving full-year housing, the FMV of that housing was $750 per month for one person and $1,100 per month for the other.

[15] The housing was either owned or leased by the Hospital and provided directly to the workers furnished by the temporary personnel agencies.

[16] The Hospital also reported on lines 11 and 28 the amounts it paid to the personnel agencies for the labor.

To determine whether the FMV of this housing might have been allowable on the contract labor lines, we questioned the Hospital further. The Hospital explained that it had not reported the FMV of the housing to IRS as a fringe benefit it paid to the workers. When asked why, the Hospital provided information that indicated that it had used the IRS "working condition fringe benefit" exclusion.[17] The Hospital cited Internal Revenue Code section 162(a)(2) as proof that the housing was excludible from the workers' reportable income as a business travel expense. (This Internal Revenue Code section defines "traveling expenses" to include meals and lodging.) Based on the foregoing information, the FMV of the housing provided to the workers supplied by the temporary personnel agencies was unallowable as contract labor because the Manual specifically states that travel expenses should not be reported under contract labor.[18]

As a result of the total of $548,651 in unallowable other wage-related costs ($192,224 in "cost of housing" employees and $356,427 in "cost of housing" temporary employment agency personnel), after applying the Hospital's occupational mix adjustment factor, the Hospital overstated its Part A wages[19] by $443,693, which overstated its average hourly wage by $1.5305.[20]

Salaries Incorrectly Reported as Other Wage-Related Costs

The Manual, section 4005.2, states that the other wage-related costs lines of the cost report should not include fringe benefits paid directly to employees in salaries. These fringe benefits should be left in the total salaries line.

The Hospital paid certain employees a housing allowance to defray the cost of lodging while working at the Hospital.[21] The Hospital incorrectly reclassified $484,847 in employee housing allowances, a fringe benefit paid directly to employees, from salaries to other wage-related costs, rather than leaving the amounts in salaries.

[17] The scope of this audit did not include determining whether the Hospital applied the working condition fringe benefit exclusion correctly.

[18] Conversely, if the travel expense exclusion did not apply and if the $356,427 "cost of housing" was the FMV of the housing the Hospital provided directly to the workers furnished by the temporary personnel agencies, the Hospital's wage-related cost reporting would have been contrary to the Manual because the Hospital did not report the fringe benefit to IRS.

[19] "Part A wages" refers to the numerator in the average hourly wage calculation. The numerator includes salaries, wages, and wage-related costs pertaining to Part A services, as opposed to Part B or non-Medicare services.

[20] The $192,224 in "cost of housing" employees included $86,313 assigned to Part B employees (physicians and physician assistants) and employees in excluded areas. This $86,313 was not part of Part A wages and accounts for most of the difference between the total unallowable wage-related cost amount ($548,651) and the Part A wages overstatement amount ($443,693). The rest of the difference is due to the application of the occupational mix adjustment factor.

[21] The Hospital stated that it reported the housing allowances to the IRS as income to the employees.

As a result of this incorrect reclassification, after applying the Hospital's occupational mix adjustment factor, the Hospital understated its Part A wages by $8,786, which understated its average hourly wage by $0.0303.

Combined Effect of Errors in Reporting Wage-Related Costs

The combined effect of the errors in reporting wage-related costs, after applying the Hospital's occupational mix adjustment, was that the Hospital overstated Part A wages by $434,907 ($443,693 less $8,786), which overstated its average hourly wage by $1.5002 ($1.5305 less $0.0303).

Home Office Wages and Hours

Federal regulations require that IPPS hospital costs reported for Medicare must be accurate, auditable, and sufficiently detailed to accomplish the intended purposes. The Manual, section 4005.2, states that it is important for hospitals to ensure that the wage data are accurate.

On line 14 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 home office who provide services to the hospital, such as centralized accounting, purchasing, human resources, and management. The Manual instructs a hospital to enter zero on line 14 if it cannot accurately determine the hours associated with the home office salaries allocated to the hospital.

The Hospital underreported home office wages[22] by $295,852 and hours by 15,943 because it used allocation methodologies that yielded materially inaccurate results. The Hospital used statistical allocation methodologies to estimate its home office wages and hours for the wage data, even though actual wages and hours were recorded on Partners' accounting systems. As a result, for home office wages and hours, the Hospital incorrectly reported $409,109 and 7,827 hours on its cost report, although documentation from Partners' accounting systems showed $704,961 and 23,770 hours directly assignable to the Hospital.

As a result of underreporting home office wages and hours, after applying the Hospital's occupational mix adjustment factor, the Hospital understated its Part A wages by $290,435 and hours by 15,943, which overstated its average hourly wage by $1.7302.

Hospital Salaries and Hours

Severance Pay 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.

[22] Wages here means salaries plus wage-related costs.

The Hospital incorrectly reported $102,648 in severance pay without associated hours. Because the Hospital was able to provide us with associated hours for $89,315 of the severance pay, we disallowed only the remaining $13,333.

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 $652 and understated hours by 2,138, which overstated its average hourly wage by $0.3470.

Typographical Errors in Physician Salaries

Federal regulations require that IPPS hospital costs reported for Medicare must be accurate, auditable, and sufficiently detailed to accomplish the intended purposes.

The Hospital underreported $19,049 in physician Part B salaries because Hospital personnel made typographical errors in the spreadsheet used to segregate physician salaries from other salaries for the cost report. Because Part B wages are subtracted from total salaries to arrive at the Part A wages used as the numerator in the average hourly wage calculation, this understatement of Part B salaries incorrectly increased the amount reported by the Hospital as Part A wages.

As a result of these typographical errors, after applying the Hospital's occupational mix adjustment factor, the Hospital overstated its Part A wages by $18,700, which overstated its average hourly wage by $0.0607.

Errors in Allocating Core Wage-Related Costs

The Hospital was required 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 severance pay and physician salaries caused errors in its allocation of core wage-related costs. These resultant errors caused the Hospital's Part A wages to be overstated by an additional $7,621, which overstated its occupational mix adjusted average hourly wage by $0.0247.

Combined Effect of Errors in Reporting Severance Pay, Physician Salaries, and Core Wage-Related Costs

The combined effect of the errors in reporting salaries and allocating core wage-related costs, after applying the Hospital's occupational mix adjustment, was that the Hospital overstated Part A wages by $26,973 and understated hours by 2,138, which overstated its average hourly wage by $0.4324.

Contract Labor Wages and Hours

Typographical Errors in Contract Labor Wages

Federal regulations require that IPPS hospital costs reported for Medicare must be accurate, auditable, and sufficiently detailed to accomplish the intended purposes.

The Hospital overstated its patient care contract labor costs by $52,434 because Hospital personnel made a typographical error in the spreadsheet used to accumulate contract labor totals for the cost report.

As a result of this typographical error, after applying the Hospital's occupational mix adjustment factor, the Hospital overstated its Part A wages by $51,474, which overstated its average hourly wage by $0.1671.

Unallowable Contract Labor Wages and Hours

The Manual, section 4005.2, states that the amount reported as patient care contract labor should "not include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs)."

The Hospital reported $9,623 in unallowable nonlabor costs (travel and housing) as patient care contract labor.

As a result of these unallowable wages and hours, after applying the Hospital's occupational mix adjustment factor, the Hospital overstated its Part A wages and hours by $9,447 and 21 associated hours, which overstated its average hourly wage by $0.0272.

Combined Effect of Errors in Reporting Contract Labor Wages and Hours

The combined effect of the errors in reporting contract labor wages and hours, after applying the Hospital's occupational mix adjustment, was that the Hospital overstated Part A wages by $60,920 and hours by 21, which overstated its average hourly wage by $0.1944.

CAUSES OF WAGE DATA REPORTING ERRORS

These reporting errors occurred because the Hospital:

- did not follow the cost report requirements in the *Provider Reimbursement Manual* and
- did not have adequate review and reconciliation procedures to ensure that the Medicare wage data it reported to CMS were accurate, allowable, supportable, and in compliance with Medicare requirements.

OVERPAYMENTS TO NANTUCKET COTTAGE HOSPITAL

Because of the errors in its FY 2011 Medicare cost report, the Hospital overstated Part A wages by $232,365 and understated Part A hours by 18,060. The incorrect wage data increased the Hospital's occupational mix adjusted average hourly wage from $49.0523 to $52.9095 and increased the Hospital's wage index from 1.2363 to 1.3336, overstatements of approximately 7.3 percent. As a result of the cost reporting errors, we estimated that Medicare overpaid the Hospital a total of $156,131, including $59,658 for FY 2015 inpatient services and $96,473 for CY 2015 outpatient services.

OVERPAYMENTS TO 55 OTHER MASSACHUSETTS HOSPITALS

For 2015, the Hospital's wage data set the rural floor wage index for Massachusetts. All 55 acute-care hospitals in the State received the benefit of the incorrect rural floor wage index, because their CBSA wage indexes were lower than 1.3336. However, on the basis of the corrected rural floor wage index of 1.2363, only 13 hospitals should have been assigned the rural floor wage index, and 42 should have retained their own CBSA wage index, as shown in the table below.

Table: Estimated Overpayments by CBSA

CBSA Code	CBSA Description	# of Hospitals in CBSA	CBSA Wage Index (Pre-rural Floor)	Originally Assigned Wage Index (Post-rural Floor)	OIG-Corrected Wage Index	Percentage Change in Wage Index	Estimated Overpayments in CBSA
14454	Boston	40	1.2896	1.3336	1.2896	3.30%	$95,094,260
15764	Cambridge-Newton-Framingham	5	1.1185	1.3336	1.2363	7.30%	20,400,974
44140	Springfield	7	1.0389	1.3336	1.2363	7.30%	10,473,592
38340	Pittsfield	1	1.0865	1.3336	1.2363	7.30%	6,828,745
12700	Barnstable Town	2	1.3154	1.3336	1.3154	1.36%	759,468
	Total	**55**					**$133,557,039**

We estimated that, because of the incorrect rural floor wage index, Medicare overpaid the 55 other acute-care hospitals in the State a total of $133.6 million, as shown in the table above, including $95.1 million for FY 2015 inpatient services and $38.5 million for CY 2015 outpatient services.

Because of the rural floor budget neutrality provision in section 3141 of the Affordable Care Act, the overpayments to Massachusetts hospitals caused underpayments to hospitals in other States.

Owing to the complexity of the multi-layered calculations involved, underpayments might not exactly equal overpayments, and only CMS could accurately estimate underpayments. However, as stated above, because of the prospective nature of the IPPS and OPPS, CMS has no mechanism to retroactively adjust final wage indexes and remedy underpayments (or recover overpayments) resulting from inaccurate wage data.

RECOMMENDATIONS

We recommend that the Hospital:

- ensure that all personnel involved in Medicare cost report preparation follow the requirements in the *Provider Reimbursement 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.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Partners HealthCare, responding on behalf of the Hospital, stated that the Hospital did not concur with our findings regarding unallowable housing costs and underreported home office costs and hours. The Hospital asserted that its personnel interpreted and followed the Manual correctly. The Hospital concurred with our finding regarding salaries incorrectly reported as other wage-related costs.

The Hospital concurred with our findings regarding severance pay reported without hours, typographical errors in physician salaries and contract labor wages, and some unallowable contract labor travel costs.

The Hospital "strongly" objected to our reporting the effect of the Hospital's errors on other hospitals in Massachusetts.

The Hospital's comments are included in their entirety as Appendix C.

For the reasons provided below, we maintain that our findings and recommendations are valid and that it is appropriate for us to report on the effect of the Hospital's errors to the fullest extent we can.

UNALLOWABLE WAGE-RELATED COSTS: EMPLOYEE HOUSING

The Hospital's Comments

The Hospital stated that it was proper to include as part of other wage-related costs the Hospital's cost of providing employee housing[23] in excess of the fair market value of the housing (*viz.* $192,224) because sections 2144, 4005.2, and 4005.4 of the Manual use the term "cost" rather than "value." The Hospital stated that we reached the wrong conclusion from IRS regulations, which define fringe benefits in terms of "value" for determining income to employees and "cost" for determining business deductions for employers. The Hospital also stated that if "value" is the appropriate measure of a fringe benefit for wage-related cost reporting, there would be few occasions to report other wage-related costs.

Office of Inspector General Response

We stand by our finding that the cost of providing employee housing was unallowable as an other wage-related cost because the *cost to the employer* of providing housing is not an IRS-recognized fringe benefit. The Hospital's contention that it properly reported *its cost* of providing employee housing as an other wage-related cost because the Manual uses the term "cost" rather than "value" is mistaken, as it misinterprets what the Manual plainly states. CMS requires providers to report wage data. Wage data includes "wage-related costs," which is a defined term in the Manual.[24] Wage data includes two classes of wage-related costs, "core" and "other," which have separate instructions.[25] Section 4005.2 of the Manual[26] states that an other wage-related cost "[1] *is* a fringe benefit as defined by the Internal Revenue Service *and,* [2] where required, has been reported as wages to the IRS ...." (Emphasis added.) As the Hospital acknowledges, a fringe benefit "is … essentially anything other than cash that is *provided as compensation* for services rendered (whether taxable or not)."[27] (Emphasis added.) Fringe benefits, as compensation for services, are part of an employee's gross income (unless

[23] This included some combination of mortgage or lease payments and payments for maintenance, repair, management, groundskeeping, insurance, utilities, *et cetera*, pertaining to the building(s) occupied by the employees.

[24] One cannot, as the Hospital does, isolate the word "costs" when the defined term is "wage-related costs."

[25] One cannot, as the Hospital does, isolate the instructions for one particular *core* wage-related cost (employee physicals) and apply them to an *other* wage-related cost (housing).

[26] Section 2144 of the Manual is irrelevant to reporting wage data and wage-related costs. The Health Care Financing Administration (HCFA), CMS's predecessor, stated in the preamble when announcing the current wage index reporting requirements that it was adopting the term "wage-related costs" for wage index purposes to eliminate any confusion among providers and Medicare contractors who had been referring erroneously to section 2144.1 of the *Provider Reimbursement Manual* (59 Fed. Reg. 45330, 45356 (Sep. 1, 1994)).

[27] We concur. As we noted in the body of the report, IRS Publication 15-B (*Employer's Tax Guide to Fringe Benefits*) states that a fringe benefit "is a form of pay for the performance of services."

excluded by the Internal Revenue Code),[28] and in most cases are valued at FMV,[29] which is "the amount an employee would have to pay a third party in an arm's-length transaction to buy or lease the benefit."[30]

Therefore, only the IRS-recognized value of a fringe benefit (usually FMV) constitutes the fringe benefit. It is irrelevant that, when calculating their taxes, employers may deduct the cost of fringe benefits, which can be greater than FMV, because the Manual states that other wage-related costs must be fringe benefits themselves.[31]

Not only must other wage-related costs be fringe benefits as defined by the IRS, they must be reported to IRS as wages when required by IRS.[32,33] The Hospital's interpretation of the Manual, that employer costs of providing fringe benefits may be included in other wage-related costs, would make sense only if IRS required the reporting of the employer's cost of providing fringe benefits as income to employees, but that is not the case.[34] It also is irrelevant that there would be few occasions to report other wage-related costs.[35]

Moreover, we note that even if the cost of employee housing in excess of FMV were an IRS-recognized fringe benefit, which it is not, it conflicts with the Manual's reasonable cost provisions. Section 4005.2 states that amounts reported as wage-related costs, both core and

[28] 26 CFR § 1.61.21(a).

[29] 26 CFR § 1.61.21(b). For some fringe benefits, such as noncommercial aircraft flights, the IRS has special valuation rules; housing does not have special valuation rules.

[30] IRS Publication 15-B (*Employer's Tax Guide to Fringe Benefits*).

[31] If the Manual had stated that IRS-recognized business expense deductions could be reported as other wage-related costs (which it does not), we would have raised two additional issues: (1) We would have questioned whether IRS would accept an employer's cost of providing employee housing in excess of the FMV of that housing as a business expense deduction, because, as the Hospital noted, to be deductible a business expense must be both ordinary and necessary. It would seem by definition unnecessary to spend more than the FMV of the housing to provide the housing. (2) We would have questioned the Hospital's development of the $192,224 figure from its Medicare cost report data. A business expense deduction for IRS reporting would have been developed directly from the employer's accounting records, not from its Medicare cost report. The Hospital provided no evidence that, had it been a tax-paying entity, its business expense deduction would have been $192,224.

[32] HCFA also stated in the preamble to the wage index reporting requirements that it believed retaining the IRS reporting requirement was appropriate (59 Fed. Reg. at 45358). HCFA further stated, "We believe that following IRS requirements with respect to the reporting of fringe benefits as employee income is appropriate." *Id*., at 45359.

[33] Section 4005.4 of the Manual states that for something to be an other wage-related cost, "The wage related cost [must have] been reported to the IRS, as a fringe benefit if so required by the IRS." We confirmed with CMS that this has the same meaning as the requirement set forth in section 4005.2, as further described in the preamble.

[34] If the Hospital's cost of providing housing in excess of FMV is a fringe benefit, we would have expected it to be reported to IRS on IRS Form W-2 as income to Hospital employees.

[35] In fact, HCFA stated at 59 Fed. Reg. 45358 that only in "limited circumstances" would other wage-related costs be reported.

non-core (other), must meet the "reasonable cost" provisions of Medicare:

> Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (See § 2103.) If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program (section 2102.1 of the Manual).

The Hospital, as a prudent and cost-conscious buyer, should have found other accommodations for its employees rather than pay $192,224 more than FMV rent to house employees in premises owned or leased by the Hospital.

UNALLOWABLE WAGE-RELATED COSTS: HOUSING FOR TEMPORARY EMPLOYMENT AGENCY PERSONNEL

The Hospital's Comments

The Hospital stated that it was proper to report on the contract labor lines in the wage data the $356,427 cost of providing on-island housing to temporary agency personnel who had traveled to the Hospital to work. It also stated that it was proper to report $7,898 paid by the Hospital to temporary agencies for housing expenses of their workers, which were itemized on the agencies' invoices. The Hospital stated that generally it was obligated under its contracts with temporary personnel agencies to provide housing. The Hospital also asserted that:

> [In the Manual's] instructions, the term "travel expenses" is regularly used in a series of exclusions consisting of "costs for equipment, supplies, travel expenses, or other miscellaneous items." Plainly, the CMS instructions are contemplating costs that, while potentially associated with the delivery of services, are not costs paid as <u>consideration</u> for obtaining services. The CMS instructions appear aimed at costs such as, for example, reimbursement of an employee's cab fare incurred for the purpose of picking up incidental supplies or dropping of a sample at an offsite clinical lab.

In other words, the Hospital asserted that the contractor housing was payment (consideration) for services and that CMS's prohibition on travel expenses being reported in contract labor applies only to travel expenses that are not payment (consideration) for services but are travel expenses that are reimbursable to employees (or contactors).

The Hospital further stated that the Manual's requirements for other wage-related costs do not apply to contractors because the Manual uses the word "wages," and "wages" is a "precise term" that only applies to compensation paid to employees.

Office of Inspector General Response

We stand by our finding that the cost of providing agency personnel housing was unallowable as an other wage-related cost because it is not an IRS-recognized fringe benefit. Everything we

said previously regarding the cost of employee housing applies to the cost of agency personnel housing.

We also stand by our finding that the cost of providing agency personnel housing was unallowable as an other wage-related cost because it did not represent an amount paid for services furnished under contract. If the housing was intended as payment for services, we would expect it to have been reported to IRS as income to the contractors. Therefore, as part of our audit, we obtained further information from the Hospital as to why it had not reported to IRS on IRS Form 1099 at a minimum the FMV of the contractor housing, because the Hospital cited the working condition fringe benefit exclusion in section 162(a)(2) of the IRS Code ("traveling expenses") as its reason for not reporting contractor housing to IRS. By citing this provision, the Hospital is clearly asserting that the housing was not intended as payment for services, but as payment of reimbursable business travel expenses. Pursuant to section 4005.2 of the Manual, "travel expenses" are expressly excluded from wage-related costs pertaining to amounts paid for services furnished under contract. We see no provision in the Manual that would allow the Hospital to represent to CMS that the housing was payment for services while simultaneously representing to IRS that it was reimbursable business travel expenses. The housing was a payment for services that should have been reported to IRS and was not, or the housing was a business travel expense. Either way, it should not be reported to CMS under contract labor.

Finally, we reject the Hospital's assertion that the Manual's requirements for other wage-related costs do not apply to contractors because the Manual uses the term "wages." In the rule-making process and in correspondence, CMS has indicated that hospitals may report wage-related costs (core and other) relating to contractors. CMS has not, however, written special instructions for contractor wage-related costs. In correspondence with the Hospital's consultant, provided to OIG by the Hospital, CMS stated:

> (t)he policies regarding the allowability of wage-related costs are the same for both directly hired employees and contract labor. The costs to which you refer below may only be included if they meet all of the criteria for 'other' wage-related costs. (Per diem, housing, and automobile allowances are not core wage-related costs.)

UNDERREPORTED HOME OFFICE WAGES AND HOURS

The Hospital's Comments

The Hospital stated that it properly reported its home office wages and hours using an allocation methodology approved by its then fiscal intermediary (FI) "many years" ago.[36] The Hospital supplied an affidavit from a former employee of that FI, which stated that the allocation methodology approved by the FI circa 1996 for use by the chain organization (Partners) "recognize(d) the unique and complex arrangements at Partners while also being proper and accurate for Medicare cost allocation purposes, consistent with the *Medicare Provider Reimbursement Manual* provisions."

[36] MACs have since taken over the responsibilities of FIs.

The Hospital quoted section 2307 of the Manual ("Direct Assignment of General Service Costs") as saying that an approved alternative methodology "must be applied to the cost reporting period for which the request was made, and to all subsequent cost reporting periods unless the [MAC] approves a subsequent request for a change by the provider." The Hospital noted that its FI had never objected to the home office cost methodology in previous desk reviews of Partners' Home Office Cost Statement or the individual hospitals' wage data.

Additionally, the Hospital objected to our proposed corrections to the Hospital's home office wages and hours because the changes would not "equitably allocate home office services used by the Hospital" and would reduce the average hourly wage of the home office services received by the Hospital by 43 percent. In support of its appeal for "equitable" allocation, the Hospital cited the Manual as requiring "equitable" allocation "in a manner reasonably related to the services received by the entities in the chain."

Office of Inspector General Response

We stand by our finding that the Hospital incorrectly reported home office wages and hours because it used an allocation methodology that used *estimates* that yielded results that are materially different from the *actual* wages and hours that were recorded on Partners' accounting system. The Hospital and Partners could not provide a contemporaneous description of the home office cost allocation methodology the Hospital said was approved by its FI circa 1996 in support of its position that Partners' home office costs could be allocated among the Hospital and Partners' other controlled organizations using estimated rather than actual wages and hours. Nor could they supply contemporaneous documentation of the FI's approval. Rather, the Hospital referenced an affidavit executed in 2016 by a former employee of Partners' former FI, which stated that the methodology had been approved and was "proper and accurate for Medicare cost allocation purposes, consistent with the Medicare Provider Reimbursement Manual provisions." However, the affidavit does not support the hospital's position because it provides no specific details regarding the allocation methodology. Further, the affiant had no personal knowledge pertaining to the Hospital and its current MAC, as he left the employ of Partners' former FI in 2004. The Hospital did not become affiliated with Partners until 2006.

Moreover, the few methodology details supplied in the 2016 affidavit would support a conclusion that no home office expenses would have been allocable to the Hospital under the methodology allegedly approved in 1996. Specifically, the affidavit states that "(o)nly the founding member hospitals' central services were transferred to, and performed by, Partners. These services included billing, general accounting, legal and purchasing. These were deemed Core Facilities. The central services for the other facilities (Non-Core Facilities) continued to be performed by those Non-Core Facilities." However, the Hospital is a non-core, non-founder hospital that only joined Partners in 2006.

We also reject the Hospital's use of section 2307 of the Manual as justification for using an inaccurate allocation methodology. That section pertains to the allocation of general service cost center costs to other cost centers *within a provider*. It does not pertain to chain organization home office costs or to home office costs in hospital wage data. As chapter 23 of the Manual explains, examples of general service cost centers are "housekeeping, laundry, dietary, operation

of plant and maintenance of plant" and "(c)osts incurred for these cost centers are allocated to other cost centers on the basis of services rendered."

Elsewhere, the Manual provides the correct methodology for the allocation of home office costs. First, costs that can be specifically identified with the consuming entity should be directly allocated to that entity. Second, costs that are not directly allocable should be "equitably" allocated to the entities "in a manner reasonably related to the services received by the entities." This is known as functional allocation; an example would be allocating the cost of a central payroll operation to chain entities on the basis of the number of checks issued to each entity. Lastly, the residual home office costs (costs that could not be directly or functionally allocated), should be allocated on a reasonable basis, which is further described (sections 3902.B through 3902.D of the Manual). Further, section 4005.2 (Line 14) of the Manual states that if a provider "cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the hospital," the provider may not claim any home office expenses.

The methodology used by the Hospital reassigned to other Partners entities $295,852 in home office wages and 15,943 in home office hours that were identified in Partners' accounting systems as being actually consumed by the Hospital. Because these wages and hours were not allocated to the Hospital, the Hospital's average hourly wage for home office and its overall average hourly wage were significantly inflated. Although Partners and the Hospital may find this "equitable," it was not proper, not accurate, and did not comply with the requirements of the Manual.

Finally, we note that the MAC's not identifying the Hospital's inaccurate home office wages and hours during prior desk reviews does not absolve the Hospital of its responsibility to report accurate data pursuant to Federal regulations and the Manual. If the Hospital believed it was required to use an old allocation methodology until it requested and received approval for a methodology change from its MAC, it should have requested the approval when it saw that the old allocation methodology yielded materially inaccurate results.

MEDICARE OVERPAYMENTS

The Hospital's Comments

The Hospital also "strongly" objected to our reporting the effect of the Hospital's errors on other hospitals in Massachusetts. The Hospital stated that our findings imply that it is responsible for payments to other hospitals, even though the Hospital "did not establish the rural floor" and is not responsible for payments to other hospitals that result from the establishment of the rural floor.

Office of Inspector General Response

The Hospital's wage data affected the payment rates for all other hospitals in the State. As stated in our report, the nationally-based, budget-neutral rural floor is established in Federal law. Information regarding the effect inaccurate wage data has on the calculation of hospital payments is pertinent to CMS, policymakers, and others interested in hospital payment issues.

To this end, we have issued hospital wage data reviews since 2004, and we reported the effect of a hospital's errors to the fullest extent possible. In past reviews, this has meant reporting the effect on all hospitals in the audited hospital's CBSA. Reporting the statewide effect of Nantucket Cottage Hospital's errors is in keeping with our long-standing approach of providing readers of our reports with complete, relevant information. Had we been able to accurately estimate the effect of the Hospital's errors on hospitals outside of Massachusetts, we would have included that estimate as well.

CONCLUSION

Although it is prudent that Partners and the Hospital "seek guidance from National Associations, consultants, and experts in Medicare law" with respect to the filing of cost reports, including wage data, ultimately each hospital is solely responsible for submitting accurate data as required by Federal regulations and the Manual. Effective internal controls are necessary to produce cost reports that are accurate and in compliance with Medicare requirements. Reliance on external reviews, such as MAC desk reviews of wage data, cannot be substituted for an effective internal control program.

OTHER MATTERS

PARTNERS' HOME OFFICE COST STATEMENT

Health care chains may allocate to member entities home office costs for centralized services such as accounting, purchasing, human resources, and management. The Home Office Cost Statement, Form CMS 287-05, allocates home office costs to the entities in the chain based on the services received by the entities. These allocated costs are used to complete each hospital's Worksheet S-3 wage data.

Federal regulations (42 CFR § 413.17(a)) state that "costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control [e.g., home offices] are includable in the allowable cost of the provider at the cost to the related organization." This is restated in section 4017 of the Manual, which provides instructions for completing Worksheet A-8-1. Also, section 4005.2 of the Manual provides that Line 14 on Worksheet S-3, Part II, is for salaries and wage-related costs for home office personnel, which "must be shown as the cost to the related organization" (emphasis in original).

We did not audit Partners' entire Home Office Cost Statement, which allocated costs to 15 entities, because it was outside the scope of this audit. However, we analyzed the section pertaining to Nantucket Cottage Hospital. We noted that for Nantucket and other facilities in this section the amounts listed as directly allocated costs were actually the amounts billed internally by the home office to those entities (also known as "charges"). Partners could not demonstrate that the charges to each hospital represented the cost of the services received by the hospital.

Our scope did not include reviewing the home office costs of Partners' other hospitals. However, because of our concerns about potential inaccuracies in wage data resulting from

Partners reporting charges instead of costs, we have referred this matter to the Medicare administrative contractor.

INSUFFICIENTLY DETAILED TIME RECORDS

Federal regulations require that IPPS hospital costs reported for Medicare must be accurate, auditable, and sufficiently detailed to accomplish the intended purposes. Federal regulations state that, in general, a hospital should allocate physician compensation costs according to the time spent on physician services to the provider (Part A), physician services to patients (Part B), and activities, such as funded research, that are not paid under either Part A or Part B (42 CFR § 415.60).

Federal regulations further state that a hospital should "maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier" (42 CFR § 415.60).

For the one salaried physician with Part A wages, the Hospital allocated salary and hours between Part A and Part B. The time records (timestudies) used by the Hospital to allocate this physician's time were not sufficiently detailed to allow auditing or validation. Because of the inadequate nature of the timestudies, we are unable to determine the percentages of this physician's time that should have been allocated to Part A and Part B.

WAGE DATA REPORTED ON INCORRECT LINES

During the course of our review, we noted that Part B salaries and hours for nonphysician practitioners were reported on line 5, the line for physician Part B salaries and hours. Although this wage data reporting error had no effect on the Hospital's wage index, we note that the Manual's instructions were not followed.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Dominican Hospital Reported Overstated Wage Data, Resulting in Medicare Overpayments	A-09-14-02032	June 2016
Danbury Hospital Reported Overstated Wage Data, Resulting in Medicare Overpayments	A-01-14-00506	January 2016
Review of the Altoona Regional Health System's Reported Fiscal Year 2006 Wage Data	A-03-08-00019	August 2009
Review of Via Christi Regional Medical Center's Reported Fiscal Year 2005 Wage Data	A-07-07-02726	December 2008
Review of Thomas Jefferson University Hospital's Reported Fiscal Year 2006 Wage Data	A-03-07-00024	November 2008
Review of Kaiser Foundation Hospital-Vallejo's Reported Fiscal Year 2005 Wage Data	A-09-07-00083	September 2008
Review of Ochsner Foundation Hospital's Reported Fiscal Year 2005 Wage Data	A-01-08-00519	August 2008
Review of Henry Ford Hospital's Reported Fiscal Year 2005 Wage Data	A-05-07-00063	August 2008
Review of Touro Infirmary's Reported Fiscal Year 2005 Wage Data	A-01-08-00513	July 2008
Review of West Jefferson Medical Center's Reported Fiscal Year 2005 Wage Data	A-01-08-00516	July 2008
Review of Tulane Medical Center's Reported Fiscal Year 2005 Wage Data	A-01-08-00518	July 2008
Review of Broward General Medical Center's Reported Fiscal Year 2006 Wage Data	A-04-07-06034	July 2008
Review of East Jefferson General Hospital's Reported Fiscal Year 2005 Wage Data	A-01-08-00515	June 2008
Review of Methodist Hospital Wage Data for the Fiscal Year 2009 Wage Indexes	A-06-07-00098	June 2008
Review of Duke University Medical Center's Reported Fiscal Year 2006 Wage Data	A-01-07-00511	April 2008
Review of St. Peter's University Hospital's Reported Fiscal Year 2005 Wage Data	A-02-07-01047	February 2008
Review of UMass Memorial Medical Center's Reported Fiscal Year 2006 Wage Data	A-01-07-00509	January 2008
Review of Hospital Wage Data Used To Calculate Inpatient Prospective Payment System Wage Indexes	A-01-05-00504	February 2007

Report Title	Report Number	Date Issued
Review of University of California, Davis Medical Center's Reported Fiscal Year 2004 Wage Data	A-09-06-00024	September 2006
Review of University of California, Irvine Medical Center's Reported Fiscal Year 2004 Wage Data	A-09-06-00025	September 2006
Review of University of California, Los Angeles Medical Center's Reported Fiscal Year 2004 Wage Data	A-09-06-00026	September 2006
Review of University of California, San Diego Medical Center's Reported Fiscal Year 2004 Wage Data	A-09-06-00027	September 2006
Review of University of California, San Francisco Medical Center's Reported Fiscal Year 2004 Wage Data	A-09-05-00039	September 2006
Review of the North Shore University Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes	A-02-05-01008	May 2006
Review of Controls to Report Wage Data at Sarasota Memorial Hospital for the Period of October 1, 2002, through September 30, 2003	A-04-05-02001	May 2006
Review of Controls to Report Wage Data at Florida Hospital Heartland for the Period January 1, 2003, through December 31, 2003	A-04-05-02002	May 2006
Review of Valley Baptist Medical Center's Reported Fiscal Year 2003 Wage Data	A-06-06-00037	May 2006
Review of the Hospital Wage Index at Baylor University Medical Center	A-06-06-00038	May 2006
Review of the Saint Francis Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes	A-02-05-01004	April 2006
Review of Medicare Inpatient Wage Rate Assignment at Lehigh Valley Hospital, Allentown, Pennsylvania	A-03-05-00003	April 2006
Review of Controls to Report Wage Data at Citrus Memorial Hospital for the Period of October 1, 2002, Through September 30, 2003	A-04-05-02003	April 2006
Review of St. Joseph Hospital's Reported Fiscal Year 2004 Wage Data	A-09-05-00040	April 2006

Report Title	Report Number	Date Issued
Review of Riverside Medical Center's Reported Fiscal Year 2003 Wage Data	A-05-05-00022	March 2006
Review of Medicare Inpatient Wage Rate Assignment at Hackettstown Regional Medical Center, Hackettstown, New Jersey	A-03-05-00005	March 2006
Review of Day Kimball Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes	A-01-05-00506	November 2005
Review of Condell Medical Center's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes	A-05-05-00021	August 2005
Review of Hartford Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes	A-01-04-00524	June 2005
Review of Windham Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes	A-01-04-00511	April 2005
Review of Cape Cod Hospital's Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indices	A-01-04-00501	November 2004

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $20,919,480 in wages and wage-related costs and 360,352 in hours for employees, home office staff, and contractors that the Hospital reported to CMS on its FY 2011 Medicare cost report. We evaluated compliance with selected Medicare cost reporting requirements. We limited our review of the Hospital's internal controls to those related to accumulating and reporting wage cost data for its FY 2011 cost report. This report does not represent an assessment of any claims submitted by the Hospital for Medicare reimbursement.

Our audit work included contacting CMS and the Hospital's Medicare Administrative Contractor from February 2015 through April 2016. We performed fieldwork at the Partners HealthCare offices in Boston, Massachusetts, from March 2015 through April 2016.

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 the Hospital's financial statements for the period under review and verified that Hospital wage data reconciled to the financial statements;
- obtained Hospital payroll, general ledger, accounts payable, and other documents to support reported wage data and reconciled wage data from selected cost centers to the detailed support;
- obtained documentation regarding the nature of services that employees and contract labor provided to the Hospital;
- confirmed our understanding of IRS fringe benefits rules with IRS;
- determined the effect of the findings on Medicare inpatient and outpatient payments to the Hospital and to 55 other Massachusetts hospitals; 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.

November 29, 2016

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

RE: Report number: A-01-15-00502

Dear Mr. Lamir:

We thank you for the opportunity to respond to the OIG's draft report entitled *"Nantucket Cottage Hospital did not accurately report certain wage data for fiscal year 2011."* Nantucket Cottage Hospital as do all affiliated hospitals of the Partners HealthCare System takes very seriously its obligation to file an accurate Medicare Cost Report in compliance with all applicable rules and regulations. As needed, we seek guidance from National Associations, consultants, and experts in Medicare law to confirm our understanding of very complex issues relating to the Medicare Cost Report and to wage index filings.

We have reviewed the OIG's findings and recommendations and offer our response to these findings in the order presented in the draft report.

Unallowable Wage-Related Cost: Employee Housing

Cost of Employer Provided Housing (in excess of employee paid rent) Is Includible as an "Other" (i.e., Non-Core) Wage Related Cost.

The Hospital provided housing to employees who paid FMV rent to the Hospital. The Hospital reported the cost of providing the housing in excess of the rent received ($192,224) as an "other" or non-core wage related cost.

The Office of Inspector General's draft report improperly takes the view that such cost should be disallowed. In doing so, the report explained:

> The Manual states that an other wage-related cost must be a fringe benefit as defined by the Internal Revenue Service (IRS) and, where required, must have been reported to the IRS as wages.

We understand from the draft report that the second requirement – that the cost must have been reported to the IRS where required by IRS rules – is not at issue in connection with housing provided to employees, because the employees to whom the Hospital provided housing paid FMV rent to the Hospital, and thus received no compensatory benefit reportable to the IRS as wages. Thus no reporting to the IRS was required. As for the first requirement – that the "other wage related cost must be a fringe benefit as defined by the Internal Revenue (IRS)" – the lynchpin of the OIG's position is that "the cost to the employer of providing the housing is not an IRS-recognized fringe benefit." Rather, the draft report contends that the IRS recognizes only "the fair market value (FMV) of housing (lodging) provided to employee or contractors as a fringe benefit."

In support of this conclusion, the draft report notes only that "We confirmed our understanding of the law with the IRS." A follow-up e-mail inquiry about this confirmation explained that OIG representatives spoke with attorneys at the IRS Tax Exempt & Governance Entities branch, who advised that the IRS recognizes only the value, and not the cost, of housing provided to workers as a fringe benefit, citing 26 CFR 1.61-21(b)(1) and (2).

With all due respect, the above conclusion – that only the value and not the cost of housing provided to workers is an IRS recognized fringe benefit for purposes of the above-cited regulation – is irrelevant. The above regulation is concerned with what is includable in the income of an employee, which is not the issue raised by the OIG. Here, the question is what can the employer-hospital claim as an "other wage-related *cost"?* To ask the question is to answer it – includable as an other wage related-cost is the cost to the employer of providing the fringe benefit. For the following reasons, housing to the employees was a fringe benefit, and the Hospital properly claimed the cost of such housing as an other wage-related cost.

As the draft report itself points out, a fringe benefit in the eyes of the IRS as described in IRS Publication 15-B is essentially anything, whether goods or services, provided to a worker as compensation for services rendered. In other words, a fringe benefit is not a limited set of things, but is broadly inclusive of essentially anything other than cash that is provided as compensation for services rendered (whether taxable or not).

The distinction the OIG draws between value and cost, therefore, does not go to the question of whether something is or is not a fringe benefit, but merely to the measure of the amount of a fringe benefit that is income to the employee (i.e. its value). That IRS rule, however, sheds no light on the question of what is the appropriate measure of a fringe benefit for wage index purposes – cost or value. The OIG appears to believe that for wage index purposes the answer lies in the tax laws. It is mistaken. CMS has its own authority and its own policy for defining an "other wage-related cost". The tax laws' use of both cost and value as appropriate measures of a fringe benefit (depending on the purpose of the calculation) supports the Hospital's position. For measuring the income that a worker realizes from receipt of a fringe benefit, the IRS has determined that the appropriate measure is value. See 26 CFR Section 1.61-21(b). For purposes of measuring the employer's deduction, the IRS has determined that the

appropriate measure is cost. See IRC Section 162(a)(1) ("[t]here shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on a trade or business, including a reasonable allowance for salaries and other compensation for personal services actually rendered"). Emphasis added. The Hospital's position for purposes of claiming an other wage-related cost is analogous to the determination by the IRS of an employer's deduction for tax purposes. If the tax laws are to provide the guidance for wage index purposes, then the proper measure is cost. This answer is borne out by Medicare's rules.

Turning to the Medicare Provider Reimbursement Manual, Section 2144, concerning Fringe Benefits, provides at 2144.2, that "It is necessary to recognize all costs which are properly classified as fringe benefits . . . ." (Emphasis added.) Section 2144.3 adds the requirement that the "costs of fringe benefits must be reasonable." (Emphasis added.) Section 2144.4 provides as examples of reportable fringe benefits:

- The "[p]rovider's unrecovered cost of meals (see Section 2145) and room and board furnished employees for the employee's convenience;"
- The "[p]rovider's unrecovered cost of medical services rendered to employees;" and
- The "[c]ost of health and life insurance premiums paid or incurred by the provider." (Emphasis added in each instance.)

The above are but a few of the examples in the Provider Reimbursement Manual that refer to the cost of fringe benefits (in fact, the first bullet specifically addresses the cost of housing). Nowhere, from our review, does Section 2144 of the PRM specify that the value of a fringe benefit is the appropriate measure of the fringe benefit for cost reporting purposes. Instead, as noted above, it specifies "cost".

Although Sections 4005.2 and 4005.4 of the Manual do not specifically relate to the cost of housing, other fringe benefits clearly are required to be included in the wage index calculation on a cost basis. For example, "the costs for employee physicals and inpatient and outpatient services that are not covered by health insurance but provided to employees at no cost or at a discount, are to be included as a core wage related cost." Instructions to Line 17 of CMS-2552-10.

As shown above, cost is the required measure of fringe benefits for both cost reporting and wage index purposes and is therefore the appropriate measure for recognizing housing expenses. IRS rules provide no contrary guidance on this subject since both the value and cost of fringe benefits are relevant for tax purposes, depending on whether the inquiry is on the income side (value) or the deduction side (cost).

Moreover, while the draft report posits that the value of housing is the relevant measure for wage index purposes, it draws no basis for distinguishing housing from other fringe benefits in this regard. If in fact the draft report is taking the position that value is the appropriate measure for all fringe benefits, there would then be little need for reporting any non-core wage index amounts. As noted at the outset, one of the requirements for inclusion of a

fringe benefit as a non-core wage related cost is that it be reported to the IRS as wages when required. Except in the unusual case of a non-taxable fringe benefit, the value of a fringe benefit provided to an employee then will always have been reported to the IRS as wages, included in the recipient employee's statement of wages on W-2, and taken into the wage base as wages. If value is the appropriate measure of a fringe benefit for wage index purposes, then, except in the unusual case of non-taxable fringe benefits, all would have been reported as wages, and there would then be nothing further to report as a non-core wage related cost.

We also observe that while we appreciate the OIG's objective of avoiding inappropriate costs to the Medicare program, adoption of a principle that only the value of housing provided to workers is includible as a non-core wage related cost, in the absence of any direction in the Provider Reimbursement Manual or other CMS directive, appears to us to be a policy matter that should be addressed in an appropriate rule making forum by CMS, which has sole authority for defining an other wage-related cost, not in the context of an audit by the OIG. This is particularly so as it is clear that whereas cost may exceed value in some instances, the opposite is just as likely. Thus, in some cases, the value of a hospital's provision of fringe benefits could drive its wage index higher, not lower. Without clear guidance from CMS on this subject, wage indexes could be skewed by some hospitals located in one area claiming the value of fringe benefits and other hospitals in another area claiming the cost of fringe benefits. In this regard, we note that the OIG has not cited to CMS guidance that states that the value of fringe benefits is the proper measure of an other wage-related cost, nor does it point to other audits of hospitals that showed that those hospitals claimed the value of fringe benefits as an other wage-related cost.

Unallowable Wage-related Cost: Housing for Temporary Employment Agency Personnel

Cost of Housing Provided to Contract Workers Is Includible as an "Other" (i.e., Non-Core) Wage Related Cost.

The Hospital provided housing to contract workers and reported the cost of the housing, $356,427, as an "other" wage related cost. This amount was the Hospital's calculated cost of providing the housing. The draft report disallowed this claimed cost for the following reasons:

> First, the cost to the Hospital of providing the housing did not represent an amount paid for services furnished under contract. Second, the cost to the Hospital of providing the housing (as opposed to the FMV of the housing) is not an IRS-recognized fringe benefit and therefore does not meet the Manual's requirements to be considered an other wage-related cost.

Respectfully, the Hospital disagrees with this reasoning. With respect to the first stated reason, while the specific provisions of the various contracts the Hospital had with contract labor vendors differed in terms of housing, they generally obligated the Hospital to provide housing. Some specifically provided that if the Hospital was not providing housing, the contract fees would be higher since the housing would have to be provided by a party other than the Hospital and paid for by the vendor or worker. In short, the Hospital was obligated under the

contracts for contract labor to provide housing, and to that extent the cost of the housing provided clearly did represent an amount paid for the contract services, as it was a condition of obtaining the contract labor. Accordingly, on reflection, the first reason appears to be essentially the same as the second, namely – only the value and not the cost of housing can be taken into account, as only the value of the housing provided to workers is an IRS recognized fringe benefit, and only the value of the housing provided represents the amount paid for the contract labor received.

For the same reasons stated above in the context of housing provided to employees, cost is plainly the correct measure of housing provided to contract laborers for purposes of calculating other wage related costs.

The OIG, however, also dismissed the possibility of the Hospital claiming the FMV of the housing provided to contract laborers. Again, while the rationale is unclear, the apparent reason is that the Hospital admittedly did not report to the IRS the value of the housing provided, and thus failed the requirement in the Manual that fringe benefits, to qualify as a non-core wage related cost, must have be reported to the IRS, at least "where required."

Specifically, the instructions to Form CMS-2552-10 provide in connection with the IRS reporting requirement only that, for a fringe benefit to be included as an "other" wage related cost:

> The wage-related cost is a fringe benefit as defined by the Internal Revenue Service and, where required, has been reported as wages to the IRS.

Form CMS-2522-10, Section 4005.2, Part II, Line 18.c. (emphasis added).

Unlike the term "fringe benefit," the term "wages" is a precise term with a specific meaning – i.e., compensation paid to an employee by an employer. Compensation paid to a non-employee contract laborer is not wages, and reporting of such compensation, therefore, is not required by the above instruction. In short, lack of reporting to the IRS is not a basis for excluding fringe benefits provided to non-employee contract laborers.

In addition, in the vast majority of cases, the Hospital was not required as a matter of tax law to report the value of housing provided to contact laborers because it qualified as a working condition fringe benefit under Section 162(a)(2), which excludes housing provided to workers who temporarily are on assignment in a location away from home, with "temporary" generally defined as a work assignment with an expected duration of one year or less.

The OIG draft report concluded, however, that even acknowledging this exception to the IRS reporting requirements for temporary housing, the cost (or value) of housing provided to contact laborers was still not includible as a non-core wage related cost because such housing then qualified as a "travel expense" under the Internal Revenue Code Section 162(a)(2), and the instructions to CMS-2552-10 expressly provide that "travel expenses" are not includible as a non-core wage related cost.

The draft report, however, engages in no analysis to equate the term "travel expenses" as used in the instructions to CMS-2552-10 with the term "travel expenses" as used in IRC Section 162(a)(2). In the CMS-2552-10 instructions, the term "travel expenses" is regularly used in a series of exclusions consisting of "costs for equipment, supplies, travel expenses, or other miscellaneous items." Plainly, the CMS instructions are contemplating costs that, while potentially associated with the delivery of services, are not costs paid as consideration for obtaining services. The CMS instructions appear aimed at costs such as, for example, reimbursement of an employee's cab fare incurred for the purpose of picking up incidental supplies or dropping a sample at an offsite clinical lab. Travel expenses for purposes of Section 162(a)(2), on the other hand, are costs incurred as a condition of obtaining worker services, and essentially represents amounts paid in consideration of the receipt of worker services. There is no connection between the two, and the exclusion for travel expenses in the CMS instructions therefore has no application to temporary housing provided to workers in order to obtain their services. Therefore, the Hospital is entitled to treat such expenses as other wage related costs.

Salaries Incorrectly Reported as Other Wage-Related Cost

We concur with this finding

Home Office Wages and Hours

The home office cost and statistic allocation methodology that is reflected on the Hospital's cost report under review has been used consistently by Partners HealthCare System for many years. This methodology to allocate home office costs to all Partners entities was constructed with the MAC's input and guidance, and ultimately its approval. Importantly, this methodology has been reviewed and audited by the MAC on numerous occasions over the past two decades as part of both MAC reviews of the home office cost report and wage surveys of Partners hospitals.

The OIG proposes to revise this home office methodology solely as it pertains to NCH. While review of the Home Office Cost Report allocation methodology is within OIG's purview, consistency mandates that any recommended revisions to the home office cost report methodology should be applied to all applicable entities of the home office. Utilizing different allocation methodologies for different providers will create inconsistent and distorted results.

Moreover, the OIG incorrectly states that the "Hospital underreported home office wages by $295,852 and hours by 15,943," thus implying that the Hospital should have initiated unilateral changes in completing its cost report wage index worksheets. The Hospital, as required by the Manual, followed its approved home office cost allocation methodology. To attack the allocation methodology approved by the MAC is to ignore CMS' clear and longstanding requirement that any changes to the cost finding and allocation methodology to be used by providers and their home office may be implemented ***only*** with the prior permission of the MAC. *See*, Provider Reimbursement Manual, Part I, Section 2307.

Moreover, once a unique allocation methodology has been approved by the MAC, Section 2307 requires that the approved alternative methodology "must be applied to the cost

reporting period for which the request was made, and to all subsequent cost reporting periods unless the intermediary approves a subsequent request for a change by the provider." The contention by the OIG that the Hospital should have altered its reporting methodology is contrary to the Manual and belies its own recommendation on page 12 of its draft report that the Hospital "ensure that all personnel involved in Medicare cost report preparation follow the requirements in the *Provider Reimbursement Manual.*" The Hospital and Partners followed the methodology approved by the MAC and *required* by the Manual.

In addition to the OIG's recommendation being incorrect as a matter of procedure, it ignores the Manual provisions that govern allocating home office costs to the components in a chain, which allow certain allowable costs to be allocated "on a basis designed to equitably allocate the costs" over the chain components "in a manner reasonably related to the services received by the entities in the chain." Form CMS 287-05, Section 3902.C. This is precisely what Partners and the MAC did many years ago and which they, and the Hospital, have consistently followed through years of annual audits. Indeed, Partners has provided CMS and the MAC with the affidavit of Robert Baroutas, the former Director of Audit and Reimbursement at Partner's MAC, who confirms that the unique home office allocation method was developed jointly by Partners and the MAC and thus was approved by the MAC as required by applicable CMS directives. The current methodology, again approved by the MAC, assigned a value to the Hospital that, we believe, "equitably allocate[s] the costs [of the home office services] received by the [Hospital]." Form CMS 287-05, Section 3902.C. As we have noted, and the OIG agrees, changes to one provider's allocation requires corresponding changes in others in order to maintain the integrity of the overall allocation. The OIG states that the effect is most likely immaterial given the size of the OIG's corrections. The materiality of the OIG's recommended changes on the other Partners entities, by virtue of their relative size, likely is small, although, we emphasize, it would result in correspondingly higher payments to those entities. The key question, however, is whether the changes proposed by the OIG also equitably allocate home office services to the Hospital. We strongly believe they do not: the changes proposed by the OIG will reduce the average hourly wage of the home office services received by the Hospital by 43 percent. This unreasonable reduction essentially eliminates recognition of the full depth and breadth of home office resources – administrative, financial and information systems - provided to the Hospital, further supporting the logic of the CMS rule that requires changes in the Home Office Cost Allocation to be evaluated and implemented with the approval of the MAC in the context of the entire allocation methodology to ensure that home office costs are allocated equitably to all entities in a manner that is reasonably related to the home office services received. In fact, ensuring that the allocation is considered equitable and reasonable by both the MAC and the home office provider is precisely why Medicare requires that the MAC work with home office providers to develop or change allocation methodologies. An OIG audit is not the occasion for making changes in home office allocation methodologies and is not sanctioned by the Manual. The Manual requires collaboration to ensure that the allocation methodology is consistent across all entities served by a home office. The OIG's proposed finding would result in some home office costs being allocated one way and the remaining costs being allocated on a completely different basis, which violates a basic tenet of cost allocation.

To summarize, the OIG's unilateral home office cost allocation finding that the Hospital should have made changes in the home office wages and salaries it reported is directly counter to Medicare instructions that clearly require that the MAC prospectively approve any

and all changes to a home office cost allocation, and it ignores the clear Manual provision that requires any approved new allocation methodology to continue to be followed in the future. Moreover, it is inconsistent with Medicare's requirement that the MAC and the Home Office Provider collaborate in developing home office allocation methodologies to ensure that, in fact, allocating home office costs to the components in a chain will be done "on a basis designed to equitably allocate the costs" over the chain components "in a manner reasonably related to the services received by the entities in the chain."

Therefore, we urge the OIG to limit its finding pertaining to the home office cost report methodology to a recommendation that the MAC prospectively review the Partners home office cost allocation methodology with Partners and all affected entities to ensure that it continues to allocate home office costs equitably and in a manner reasonably related to services received.

Severance Pay Reported Without Hours

We concur with the findings and will strengthen our review and reconciliation process

Typographical Errors in Physician Salaries

We concur with the findings and will strengthen our review and reconciliation process

Typographical Errors in Contract Labor Wages

We concur with the findings and will strengthen our review and reconciliation process

Unallowable Contract Labor Wages and Hours

Of the $9,623 of cost identified as unallowable, we concur with the findings as they relate to $1,725 in travel expenses. We will strengthen our review process to ensure these costs are excluded from future filings. However, as to the $7,898 in housing costs, these are allowable costs as noted above.

CAUSES OF WAGE DATA REPORTING ERRORS

We object to the overall characterization of all these findings as "errors" and the attribution of these so-called errors to the Hospital not understanding or following cost report instructions in the PRM. The Hospital acknowledges there were errors which, although regrettable, amounted to only 17 percent of the impact on the Hospital's hourly wage of all the OIG's findings.

As to the two major findings, Housing (employee and contractor) and Home Office Wages and Salaries, the Hospital did in fact follow the instructions in the Manual regarding the reporting of these salaries and hours in the wage survey.

The OIG has provided no logical support from the Manual or applicable regulations for its position that the Hospital's reporting of wages and hours for Housing and Home Office is incorrect. The Hospital's reporting of Housing and Home Office costs was not in error. The Hospital has provided clear support for its position that its reporting of these salaries and wages was correct based on the Manual instructions and, importantly, the interpretation of experts it has secured, including well-experienced Counsel. We strongly urge the OIG to reconsider its findings in light of the Manual instructions and analysis provided by the Hospital.

MEDICARE OVERPAYMENTS

We also strongly object to the inclusion of any estimates of payment impact on any other hospital, be it in Massachusetts or elsewhere, in the OIG's findings. The Hospital filed its cost report and wage survey to the best of its ability under its reasonable interpretation of the instructions in the Manual. As stated above, the Hospital believes that its interpretation is correct.

The inclusion of the impact on other hospitals in the OIG's findings strongly implies that the hospital is somehow responsible for payments to other hospitals in addition to the payments it receives for services rendered to Medicare beneficiaries. It is not. The Hospital did not establish the rural floor. Nor is it responsible for payments to other hospitals that may result from the establishment of a rural floor. We urge the OIG to delete any estimates of the impact of its findings on any other hospital, be it in Massachusetts or elsewhere in the country and to limit its findings to those directly related to the Hospital.

Again we would like to thank you for allowing us the opportunity to respond to this report.

Sincerely,

/John O'Leary/

John O'Leary
Corporate Director, Revenue and Reimbursement
Partners HealthCare System, Inc.

cc: Margot Hartmann, MD

Original sent by FedEx on 11/29/16

399 Revolution Drive, Somerville, MA 02145