

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Hutto/Saxon</i>	DATE <i>2-10-14</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000275</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Mr. Neek</i> <i>Extend until 2/28/14, see</i> <i>attached e-mail.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>2-20-14</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. <i>Cleared 3/21/14, letter attached.</i>			
2.			
3.			
4.			



February 3, 2014

Tony Keck
Director
SC Health and Human Services
P.O. Box 8206
Columbia, SC 29202

RE: State Medicaid Disproportionate Share Audits
Problem with Myers & Stauffer Audit Finding
Conway Hospital – Provider Number 229173

Dear Mr. Keck:

As a dedicated provider of Medicaid services to the state of SC and a Medicaid Disproportionate Share Hospital, we have participated in the multiple mandated Medicaid DSH Audits of our data and related cost reports. Over the course of the engagements we have taken issue with a few of the audit adjustments made by the firm hired – Myers & Stauffer (formally Clifton Gunderson and formally PHBV Partners). We have been able to successfully resolve those issues up until recent months.

Specifically, we disagree with Myers & Stauffer's disallowance of our Physician Recruitment Loan expense. For your information, I am enclosing the correspondence and documentation which explains this issue in greater detail.

The problem that we are currently having is identifying an avenue to formally appeal these adjustments and preserving our appeal rights in this matter. Myers & Stauffer have now begun to carry forward and apply the adjustment to every year they are auditing. They have informed us that "we believe the adjustment is reasonable unless we receive guidance from the state of SC that states otherwise."

We have contacted Jeff Saxon but have not received an answer to our correspondence. We understand that he is extremely busy but still need to know how to proceed. That is why we are now bringing this matter to your direct attention. Your attention to this matter and any assistance you can offer is greatly appreciated.

If you require any additional information, please do not hesitate to contact me via telephone at 843-347-8091 or e-mail sfinlayson@cmc-sc.com.

Sincerely,

Sherry J. Finlayson
Director, Reimbursement
Conway Medical Center

cc: Mr. Jeff Saxon, Bureau Chief, SC DHHS

Saxon to
call me w/ +
TKs talk on
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FEB 05 2014

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rights are state in their
contract. He will call
Conway & respond to this –



August 19, 2013

John D. Kraft
Member
Myers and Stauffer LC
9515 Deereco Road, Suite 500
Timonium, MD 21093

RE: Notification of 2006 Audit Adjustments
Conway Hospital – Provider Number 229173
The cost report year ended 9/30/2006

Dear Mr. Kraft:

We recently received email correspondence from Abdul Arafat, Healthcare Audit Manager with notification of audit adjustments in regards to the SC Medicaid Hospital Program Notification of Final Settlement for Conway Hospital for the fiscal year ended 09/30/2006. I am writing to formally dispute an adjustment made that we were just notified of in the supporting workpapers.

Adjustment No. 2 removes \$1,280,000 of physician recruitment expense as nonallowable.

First and foremost, expenses related to the recruitment of physicians are a direct cost of patient care. The hospital is unable to function in any capacity without physicians. Every procedure performed, every diagnostic test, every single service the hospital provides cannot be done without a valid physician order under the direct supervision of a physician. There is no patient care without a physician.

Current Stark Regulations enable the hospital to actively recruit and provide provider incentives exclusively to underserved areas. The hospital has engaged independent auditors to provide a needs assessment so that we are in compliance with the Stark regulations and able to legally recruit and claim the costs for these underserved area physician recruitment incentives. We are in compliance with current Stark Regulations.

Furthermore, in support of our position, a study was performed by the Department of Health and Human Services, Office of the Inspector General. The study performed a NATIONAL REVIEW OF GENERAL AND ADMINISTRATIVE AND FRINGE BENEFIT COSTS AT HOSPITALS. The study and related findings were published in August of 1994 and there is a specific section which directly addresses "Physician Support and Recruitment Costs". The study concludes "The PRM does not currently address the issue of physician recruitment and support. Therefore, the decision to claim these costs is left up to the individual hospital based on the hospital's determination if the costs are related to patient care." The study urged HCFA to update the PRM to address "a need for more explicit

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Director, Reimbursement
Conway Medical Center

cc: Mr. Jeff Saxon, Bureau Chief, SC DHHS

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guidelines on the allowability of certain G&A and FB costs charged to the Medicare program." As a result, the PRM has been updated to specifically address certain costs that were clearly non-allowable but "Physician Support and Recruitment Costs" were not included or addressed. As such, the allowability of the decision to claim these costs continues to be left up to the individual hospital based on the hospital's determination if the costs are related to patient care. Conway Medical Center's physician recruitment costs are directly related to patient care.

We also take exception and dispute the arbitrary amount that was used to make this adjustment. The loan amount of \$1,280,000 has no correlation to the actual expense amount and the auditor knows this as stated in the adjustment. "Since the provider did not submit the loan amount expense and we could not identify it in the trial balance, we will assume that prior year balance of \$1,280,000 was completely amortized in the current year pending provider's submission of more accurate data." We did not submit additional documentation to support the amount of the loan amortized in the current year as this is the first we have been given notice of the adjustment and the arbitrary amount used incorrectly to make it. This adjustment needs to be removed in its entirety.

If you require any additional information, please do not hesitate to contact me via telephone at 843-347-8091 or e-mail sflinlayson@cmc-sc.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sherry J. Flinlayson'.

Sherry J. Flinlayson
Director, Reimbursement
Conway Medical Center

cc: Mr. Jeff Saxon, Bureau Chief, SC DHHS

Previous Value	Difference	New Value	Action
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Adjustment No. 11 Ref: 11

WPR: G-05

To exclude non-allowable physician recruitment expense which is not related to patient care (set up private practice) noted on the audited financial statement. We treated the prior year 2004 physician recruiting expense balance as fully amortized in the current year 2005. CMS Pub 15-1 Sec 2102.3 and 2304

A-8, See detail, Line 49.07

0.00 DESCRIPTION

PHYSICIAN RECRUITMENT EXPEN Replace

1.00 BASIS FOR ADJUSTMENT

A Replace

2.00 AMOUNT

0 -917,000 -917,000 Replace

4.00 LINE NUMBER

0.00 6.00 Replace

Adjustment No. 12 Ref: 12

WPR: G-05.

To remove loss on sale of assets in accordance with CMS regulations; no gain or loss on the sale or disposal of asset.

A-8, See detail, Line 13.00 SALE OF SCRAP, WASTE, ETC.

2.00 AMOUNT

8,818 -8,817 1 Replace

Adjustment No. 13 Ref: 13

WPR:

To exclude coinsurance amount reported on W/S E-3 pt. III since we included in total interim payment at line 57.

CMS Pub 15-1 Sec 2200.1 and 2304

E-3, Part III, Title XIX, Hospital, Line 36.00 Coinsurance

1.00

14,398 -14,398 0 Replace

Adjustment No. 14 Ref: 14

WPR:

To reduce total provider's cost by 10% for private hospitals per the state of SC Medicaid policy.

E-3, Part III, Title XIX, Hospital, Line 50.00 10% REDUCTION FOR PRIVATE HOSPITALS

1.00

0 -1,342,554 -1,342,554 Replace

From: Sherry Finlayson
Sent: Wednesday, August 21, 2013 6:42 PM
To: 'Saxon@scdhs.gov'
Cc: Bret Barr

Subject: Medicaid DSH Audit problem with Myers and Stauffer

Importance: High

Attachments: Conway MCR 2006 Adj 2 Exception.pdf; OIG Review of Costs at Hospitals.pdf; Non-allowable Cost WP.xls
Mr. Saxon (Jeff):

We need your help. Please find attached your copy of a letter written to dispute an incorrect adjustment made by Myers and Stauffer LC at the close of our 09/30/2006 Medicare Cost Report Audit for Medicaid DSH purposes. The situation is that they have disallowed an arbitrary amount found in the notes to our audited financial statements that is related to physician recruitment expense. We have disputed the adjustment (via e-mail correspondence and the attached letter) with Myers and Stauffer and their most recent correspondence states that they "believe the adjustment is reasonable unless we receive guidance from the state of SC that states otherwise."

You are also receiving a separate email from Barney Osborne at SCHA concerning this same matter and our appeal rights for the situation.

Any help you can offer is sincerely appreciated.

Sherry J. Finlayson
Director, Reimbursement
Conway Medical Center

Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL

NATIONAL REVIEW OF
GENERAL AND ADMINISTRATIVE AND
FRINGE BENEFIT COSTS AT HOSPITALS



JUNE GIBBS BROWN
Inspector General
AUGUST 1994
A-03-92-00017

EXECUTIVE SUMMARY

Our review of selected general and administrative (G&A) and fringe benefit (FB) costs included in hospital Medicare cost reports was performed at the request of the Subcommittee on Oversight and Investigations (Subcommittee) of the Committee on Energy and Commerce, U.S. House of Representatives. The Chairman of the Subcommittee expressed concern that costs of personal expenses, luxury automobiles, parties, entertainment, liquor and charitable and political contributions were included in the Medicare cost reports by the hospitals.

Our review at 19 hospitals and 2 home offices identified unallowable G&A and FB costs of \$50.7 million included in their Fiscal Year (FY) 1991 Medicare cost reports. We also identified \$3.5 million of costs which we have labeled as "costs for concern" because of their tenuous relationship to patient care.

Providers were primarily responsible for claiming unallowable costs. We noted, however, that HCFA's guidelines often did not explicitly describe unallowable costs.

Some of the unallowable costs that we have identified in this report are explicitly unallowable and have resulted primarily from the providers' lack of internal controls over costs included in Medicare cost reports. However, there are other unallowable costs that we have identified, as well as the "costs for concern" that appear to have resulted from differing interpretations of the guidelines contained in the Health Care Financing Administration's (HCFA) Medicare Provider Reimbursement Manual (PRM) which is the principal guideline used by providers to charge costs to the Medicare program.

The PRM, for the most part, does not provide explicit guidance on certain G&A and FB costs. Rather the PRM relies on the providers to adhere to broadly defined cost concepts involving reasonableness, relationship to patient care, and the "Prudent Buyer" concept that, in our opinion, allow providers great latitude in identifying allowable costs charged to the Medicare program.

We issued separate audit reports to the providers included in our national review recommending actions to resolve the local issues that we identified. In this report, we are recommending that HCFA revise the PRM to provide additional clarification on the allowability of specific types of G&A and FB costs for reimbursement under the Medicare program.

In revising the PRM, HCFA should consider the results of an Office of Inspector General (OIG) review¹ of G&A costs at 14 colleges and universities. One of the audit conclusions reached in the report, which was addressed to the Assistant Secretary for Management and Budget, Department of Health and Human Services, was that Federal guidelines, namely the Office of Management and Budget (OMB) Circular A-21 Cost Principles for Educational Institutions, did not provide clear guidance on the allowability of certain G&A costs. The OMB has revised the Circular to provide additional clarification on the allowability of certain G&A costs for Federal reimbursement.

On January 26, 1994, HCFA responded to a draft of this audit report. The HCFA stated that it will make an in-depth analysis of the issues identified in this report and will revise the PRM, as appropriate, to address specific categories of G&A and FB costs in order to provide better guidance to hospitals, as well as other providers and intermediaries, concerning the allowability of these costs. The HCFA comments have been summarized and incorporated in this report, and are included in their entirety as Appendix B.

¹Office of Inspector General National Audit of General and Administrative Indirect Costs at Selected Colleges and Universities (A-01-91-04008) January 28, 1992.

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12	Physician Support and Recruitment Costs
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13	Miscellaneous Costs
14	Conclusions and Recommendations
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	Appendix B HCFA's Response

INTRODUCTION

BACKGROUND

As requested by the Chairman of the Subcommittee, our audit focused on G&A and FB costs included in hospitals' Medicare cost reports. The effect that any unallowable G&A and FB costs would have on Medicare reimbursement depends on which of the two methods of reimbursement a hospital is reimbursed under.

Prospective Payment System

The most common method of reimbursement is the prospective payment system (PPS) which was established by the Social Security Amendments of 1983 (P.L. 98-21). Over 80 percent of participating hospitals are reimbursed under this method. We included 16 of these hospitals in our review.

Under PPS, Medicare's payments for Part A hospital inpatient operating costs are made prospectively on a per discharge basis which are classified into diagnostic related groups (DRG). The DRG payments are fixed and are based on volume and type of service performed, regardless of actual costs. Since the payments are fixed, inappropriate G&A and FB costs have no immediate direct effect on Medicare reimbursement for inpatient services provided to Medicare beneficiaries. Inappropriate overhead expenditures, however, do directly effect Medicare reimbursement for outpatient services and for services provided by excluded units of the hospitals. Excluded units are psychiatric, rehabilitation, and alcohol/drug units of general hospitals.

The average immediate and direct effect of unallowable and inappropriate expenditures on the 16 hospitals included in our review was about 5.75 percent. As a result, 5.75 percent of the unallowable or inappropriate costs that were included on the Medicare cost reports were subject to immediate and direct reimbursement by the Medicare program.

Reasonable Cost Method

The second method of reimbursement under Medicare is what is known as the reasonable cost method. Under this method, hospitals are reimbursed for inpatient services on the basis of reasonable costs subject to applicable target rate ceilings. We have included three of these hospitals in our review.

Hospitals falling under this category are psychiatric, rehabilitation, children's, long term, and alcohol/drug hospitals. Since Medicare reimbursement to these hospitals is based on actual costs rather than a fixed payment rate, inappropriate G&A and FB costs have an immediate direct effect on their Medicare reimbursement.

For the three hospitals in our review that are reimbursed under the reasonable cost method, the average Medicare participation rate was 60.46 percent; that is, 60.46 percent of the allowable or inappropriate costs included on the Medicare cost reports by these hospitals were subject to reimbursement by Medicare.

Hospital Corporation Home Office Costs

Home office costs are not reimbursed directly by Medicare. Rather home offices: (1) must prepare a cost report identifying those costs subject to allocation to Federal programs and (2) allocate these costs to their subsidiary providers. The home office costs that are allocated in this manner are included in the subsidiary providers' Medicare cost reports, and the effect of these allocated costs on Medicare depends on whether the subsidiary providers are reimbursed under the PPS or the reasonable cost method.

SCOPE

Our review was made in accordance with generally accepted government auditing standards. The objectives of our review were to analyze selected G&A and FB costs and determine (1) if such costs were allowable, reasonable, and allocable under Medicare cost principles as set forth in the PRM; (2) the nature of the charges and the degree of relationship to patient care activities; and (3) those types of costs which may be perceived to be extravagant or otherwise inappropriate.

Our review was performed at 19 hospitals and 2 home offices (Appendix A) in response to a request from the Subcommittee which was conducting an inquiry into the health care system. The Subcommittee requested that we determine the allowability, reasonableness, and allocability of G&A and FB costs allocated to patient care and the Medicare program. We selected the 21 providers to ensure a geographic representation of hospitals nationwide.

To accomplish our objectives, we reviewed G&A and FB costs included in the FY 1991 Medicare cost reports as submitted by the selected providers, and judgmentally selected specific cost items for review. The 21 providers claimed total G&A and FB costs of \$716.8 million of which we reviewed \$228.4 million. In selecting costs for review, we included those items which we believed had the greater risk of noncompliance with Federal regulations and of being unrelated to patient care. Therefore, the results of our analysis cannot be considered representative of the overall operations of the 21 providers included in our review.

During our reviews of transactions, we classified costs into three separate categories:

- **Allowable** - The expenditure is allowable under Medicare as it benefits the provision of patient care.

• **Unallowable** - The expenditure is not related to patient care based on its nature.

• **Costs for Concern** - The expenditure, in our opinion, has questionable benefit to patient care. However, these expenditures, such as Christmas parties and costs related to employee morale, have been allowed by fiscal intermediaries or the Provider Reimbursement Review Board (PRRB).

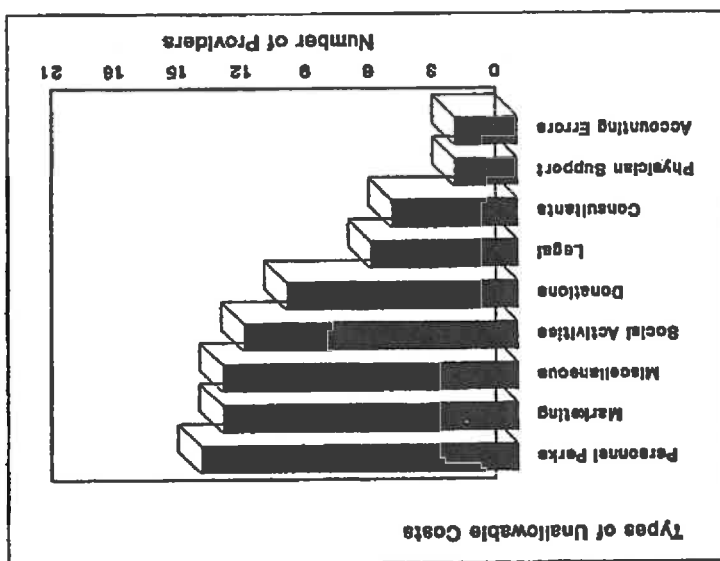
In reviewing the allowability and allocability of costs, we considered whether the costs incurred (1) were reasonable, (2) benefited patient care, (3) were necessary to the overall operation of the hospital, and (4) were deemed to be assignable to patient care in view of the principles provided in the PRM and in PRRB rulings. In reviewing the reasonableness of costs, we considered whether or not the individuals that caused the costs to be incurred acted with due prudence in the circumstances considering their responsibilities to the hospital, its employees, its patients, the Federal Government, and the public at large. We also considered the results of an OIG review of G&A costs claimed by colleges and universities and OMB's revisions to OMB Circular A-21 which was in response to this review and others performed by the U.S. General Accounting Office (GAO).

We limited the consideration of the internal control structure at each hospital because the objectives of this audit did not require an understanding or assessment of the internal control structures. Other than the issues discussed in the FINDINGS AND RECOMMENDATIONS section of this report, we found no instances of noncompliance with applicable laws and regulations. With respect to those items not tested, nothing came to our attention to cause us to believe that the untested items were not in compliance with applicable laws and regulations.

Our field work was conducted at each of the hospitals between November 1991 and November 1992. We have issued individual audit reports to each of the providers included in this review.

FINDINGS AND RECOMMENDATIONS

THE PRM SHOULD BE REVISED TO CLARIFY ALLOWABILITY OF CERTAIN G&A AND FB COSTS



We identified unallowable costs of \$50.7 million at the 19 hospitals and 2 home offices included in our review. Because 16 of the 19 hospitals were reimbursed under the PPS reimbursement method, the effect of the unallowable costs on the Medicare program was about \$2.1 million.

In addition, we identified \$3.5 million of costs that we have labeled as "costs for concern." We question the relationship of these costs to patient care but note that

similar costs have been accepted by intermediaries and, in some cases, the PRRB.

Providers are ultimately responsible for determining the allowability of costs before including them on Medicare cost reports and, in many instances, we believe it was the providers' lack of adequate internal controls which resulted in unallowable costs being included on their Medicare cost reports. In other instances, however, it appeared that the lack of explicit guidance in the PRM was, at the very least, a contributing factor to the unallowable and otherwise questionable costs being included on their Medicare cost reports.

The PRM relies primarily on three basic cost concepts for determining allowable G&A and FB costs.

1. The reasonableness of cost concept which takes into account whether the cost is of a type generally recognized as necessary for the operation of the hospital in view of the hospital's size, scope of services, and utilization (PRM, section 2102.1).
2. The relationship of the cost to patient care. This concept is defined as including all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities (PRM, section 2102.2).

3. The "Prudent Buyer" concept which requires that providers act as a prudent and cost-conscious buyer and seek to economize by minimizing costs (PRM, section 2103).

These concepts, in our opinion, are extremely subjective and allow great latitude on the part of providers in interpreting them. For example, costs may be considered related to patient care if they are common and accepted occurrences in the field of the providers' activity. This provision can be interpreted as meaning that if the majority of hospitals incur a cost, regardless of the type or nature of the cost, the cost may be construed to be related to patient care, regardless of how tenuous a relationship exists.

In calling for the application of the "Prudent Buyer" concept, the PRM does not specifically illustrate what a prudent buyer would consider a reasonable cost. Nor does the PRM provide explicit descriptions of what constitutes certain allowable and unallowable indirect costs. As a result, providers can essentially define what costs are "appropriate and helpful" and, therefore, relate to "patient care." Provider responses to our individual audit reports indicate differences in opinion among the providers in interpreting the PRM. One hospital official summed up the position taken by others when he stated that:

...hospitals are allowed to claim all incurred costs that are ordinary business expenses resulting from providing patient care and related services to Medicare beneficiaries. The regulations permit providers to seek reimbursement for any costs not clearly precluded, even if such costs subsequently may be determined to be nonreimbursable under the Medicare program.

Such a position perhaps explains many of the unallowable costs that were included in the Medicare cost reports. We found numerous instances of costs charged to Medicare for parties, liquor, golf club outings, membership fees in social clubs that hospitals believe are allowable, but, in our opinion, have no relationship to patient care and are, therefore, unallowable.

Since we issued detailed audit reports on our findings at each of the providers included in our review, we are not going to duplicate the same information here. In this report, we are emphasizing those areas which we believe require a revision to the PRM to ensure consistency among providers and to reduce the subjectiveness that now exists in interpreting the requirements for Medicare reimbursement.

Following are broad categories of cost requiring clarification in the PRM.

Employee Benefits and/or Perquisites

At 20 providers we found numerous unallowable and questionable (costs for concern) costs for employee benefits and/or perquisites. We believe that, although these costs

benefit the providers' executives and/or employees and may improve their morale, the costs are not normally recognized employee F.B.s, and are not related to patient care. Examples of the costs included in this category follow.

One provider charged \$167,508 on its cost report for such expenditures as: costs for team sports, t-shirts and tannery packs, boat cruises, musicians for retirement events, conference tickets for spouses, baseball box seats and related parking and food, golfing fees/dues and meals, liquor for the executive Christmas party and meals to employees, board members and physicians (\$26,892); gifts to employees, board members, and physicians for recognitions, retirements, and other special occasions (\$11,644); flowers for employees, volunteers, special events, etc. (\$8,256); and portraits, photographs for board members and for promotional and charity events (\$7,718). The same hospital included on its cost report \$176,745 for employee parties and other employee activities.

Another provider charged \$99,260 on its cost report for various employee social activities including parties, picnics, bus trips, Broadway show tickets, concert tickets and other similar items (\$46,551); gifts for employees including Thanksgiving turkeys (\$18,709); golf shirts, sweatshirts, watches, and mugs with the provider's logo provided to employees, board members and friends of the provider (\$17,709); and balloons and flowers for employees and friends (\$6,814).

Another provider charged \$209,960 for: sponsorship of employee participation in various sporting events including tennis tournaments and foot races (\$36,500); employee social activities including parties, picnics, and other similar items (\$61,413); employee fitness programs and social activities, including participation in sporting events, award banquets, and neon sunglasses given to employees during the provider's sport tournaments (\$29,787); and unreimbursed cost of movie tickets, football tickets, bowling league fees, and similar items provided to employees free or at a discount (\$82,260).

In responding to our reports, there was much divergence of opinion among the providers as to what was an allowable cost. Several providers believed the costs to be allowable. For example, in responding to our questioning the cost of a musician at a managers' dinner meeting, a hospital official stated that the cost was allowable because

...background music contributed to the productivity of the dinner meeting.

This same administrator stated that since the PRM did not specifically exclude alcohol, it was an allowable cost. Another hospital administrator agreed that liquor served at an employees' banquet was allowable because:

...the annual employee banquet is a tool used in...employee recruitment and retention programs in an effort to demonstrate to deserving employees the hospital's appreciation for a job well done.

Other providers agreed that some of the cited costs were unallowable. One provider responded that it could accept a decision by the Federal Government not to pay for these items but clear, consistent, prospective guidelines are necessary. In the meantime, the provider had withdrawn from Medicare reimbursement many of these items we identified. Another provider admitted that many of these costs were not specifically addressed by Medicare rules and regulations and that it looked forward to greater clarification as a result of this audit.

One provider, in defending its decision to include these employee benefits in its Medicare report, stated that there appeared to be "much uncertainty" over the allowability of various "employee fringe benefits" and cited a PRRB decision and the HCFA Administrator's decision to override the PRRB to prove its point.

This "uncertainty" regarding these types of employee benefits is not restricted to Medicare providers. Rather, it appears to be a Governmentwide concern. In discussing these types of costs and their relationship to employee morale and welfare at Subcommittee hearing on the Federal procurement system, a GAO representative questioned their reasonableness and stated that:

...without more specific guidance, deciding what constitutes reasonable expenditures in these areas is tantamount to navigating a minefield.

The GAO representative was speaking about the Federal Acquisition Regulation but, in our opinion, the thought applies to the PRM as well. The PRM does not specifically address these types of employee benefits. The PRM does define FBs and states that, although FBs inure primarily to the benefit of the employee, there may also be some intrinsic benefit to the provider, such as increasing employee work efficiency and productivity, reducing personnel turnover, or increasing employee morale. The PRM further states that costs for perquisites--two examples are given, uniforms and laundry--are not classified as FBs but may be allowable to the extent that they are reasonable and related to patient care.

There have been rulings from the PRRB which partially support the providers' position regarding the allowability of costs that appear to improve staff morale. For example, the PRRB issued a decision (85-D62) which overturned an intermediary's disallowance for a provider's Christmas party. The PRRB agreed with the provider that the Christmas party costs were allowable since the costs improved morale and general working conditions.

The PRRB, in a later decision (91-D60) also agreed with a provider that the costs of football tickets provided to employees were allowable as a FB. Upon review, however, the HCFA Administrator overruled the PRRB decision. The Administrator stated that:

At 20 providers we found numerous unallowable costs relating to advertising, public relations, and donations. The primary reason why we have grouped these costs into one category is that, among some providers, there is a fine line between donations and public relations. For example, a provider included \$23,741 in its Medicare cost report for contributions to the Easter Seal Society, the Arthritis Foundation, and for tickets to the Governor's banquet. According to the provider, these contributions constitute allowable advertising costs that are incurred in connection with its public relations activities and are primarily concerned with the presentation of a "good public image."

This provider was not unique in its contention that contributions contribute to the "good public image" of the institution. Another provider included in its Medicare cost report

Advertising/Public Relations/Donations

We also noted that the OMB Circular A-21 allows for employee morale and health and welfare costs, including recreational activities. The OIG recommended that this provision be clarified to show when allowable recreational activities become unallowable entertainment.

- Costs of alcoholic beverages.
- Costs of goods or services for personal use.
- Cost of entertainment, including amusement, diversion, and social activities and any costs associated with such costs (such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities).

We noted that OMB in revising its Circular A-21 determined that the following types of costs are unallowable for Federal reimbursement.

We believe the Administrator's statement that there is nothing to suggest that employees' behavior to patients is affected by perquisites such as free football tickets and alcoholic beverages applies to other types of perquisites that we have identified. The PRM should be revised to reflect this position.

...although the PRM recognizes certain usual fringe benefits to employees as allowable costs, to be allowable, the benefit must meet the test of reasonableness and be related to the provision of patient care. There is no indication that the furnishing of these football tickets and alcoholic beverages or the lack thereof has any bearing on the delivery of patient care by the provider, including the quality of that care. There is nothing in the record to suggest that these employees would not serve their patients the same regardless of whether the provider furnished free football tickets and/or alcoholic beverages.

At nine providers we found unallowable costs for dues and memberships in various clubs. One provider included in its Medicare cost report \$14,940 of costs for membership and dues at a golf club and other private clubs for its top executives. The hospital responded that it had confirmed the legitimate business purpose of these expenses, however, it admitted that some of the expenses may not be considered allowable under a strict

Dues and Memberships

We believe that HCFA should clarify its guidelines in the PRM to distinguish between advertising costs and donations and to clarify the types of expenditures that are allowable. We noted that OMB revised Circular A-21 by better defining allowable public relations costs and describing unallowable advertising and public relations costs. Examples of unallowable costs are costs of special events, such as conventions and trade shows; costs of displays, demonstrations and exhibits; cost of promotional items and memorabilia, including models, gifts, and souvenirs; and costs of advertising and public relations designed solely to promote the institution. The OMB also added a new section to OMB Circular A-21 which states that all donations or contributions made by an institution, regardless of the recipient are unallowable.

The PRM section 2136 states that advertising costs are allowable only when appropriate and helpful in developing, maintaining, and furnishing covered services to Medicare beneficiaries. Section 2136.1 states that advertising costs incurred in connection with a provider's public relations activities are allowable if primarily concerned with the presentation of a "good public image" and directly or indirectly related to patient care. Section 2136.2 lists fund raising costs and costs of advertising to the general public to increase patient utilization of the provider's facilities as unallowable. The PRM does not specifically address donations and contributions. However, the PRRB in a decision (80-D88), dated October 10, 1980, stated that payments made to specific civic and charitable organizations did not constitute Medicare reimbursable costs, as they were not related to patient care.

Some of the questioned costs were strictly marketing. For example, one hospital developed a marketing program aimed at encouraging senior citizens to use their services. This program was similar to a frequent guest program offered by major hotel chains. Members of the program receive various types of perks such as a free daily newspaper while admitted to the hospital, complimentary meals for guests, and gift shop discounts. The total costs of this venture amounted to \$346,548.

\$45,675 for donations and sponsorship of local events. Some of the donations went to the Florida Conservation Society, the Salvation Army, the United Way, and the Coral Gables Junior Woman's Club. The provider also sponsored a tennis championship, an Actors Playhouse, and a junior tennis tournament. These costs, according to the provider, were to present the hospital to the community as a positive friendly corporate neighbor.

interpretation of Medicare reimbursement policies. Another provider included \$1,027 for an executive to belong to a social luncheon club. The provider responded that the administrator's membership was for business meetings with physicians.

Two providers included membership costs of \$138,274 to a professional organization. These costs, however, represented an assessment from an organization in which the providers were shareholders. The organization issues preferred stock to the providers in exchange for these payments. In responding to our reports, one provider agreed that these costs did not meet the criteria established in the PRM. The other provider, however, disagreed with our conclusion and stated that:

*...its annual assessments are reimbursable under the Medicare program.
...the quantifiable benefits of membership exceeds the annual assessment.*

The PRM allows for costs associated with professional, technical, business related, and civic organizations. The PRM identifies costs associated with social, fraternal, and other organizations as being unallowable. In our opinion, these instructions are clear. We believe, however, that HCFA should clarify the PRM with regard to memberships in organizations in which providers hold ownership interest. Also, HCFA should consider revising the PRM to disallow costs associated with civic organizations. As stated in the PRM, these organizations are for the purpose of implementing civic objectives. The relationship of these civic objectives to patient care is nebulous at best. We noted that one of OMB's revisions to Circular A-21 involved the disallowance of all costs associated with civic and community organizations.

Legal

At nine providers we found unallowable costs for legal services. One provider included settlement costs of \$1 million in its Medicare cost report. The settlement was paid to the city government in order to prevent delays in the consolidation of two facilities, one of which was the provider under review. The provider contended that these costs were allowable, since the consolidation allowed the provider to operate more efficiently. This payment to the city government was voluntary and could not be classified as an allowable tax or assessment. In our opinion, this cost was not necessary for the operation of the hospital and was not related to patient care.

One provider included the costs of legal services related to investments, stocks, and bonds amounting to \$286,790. The provider agreed that these costs were unallowable but stated that the costs were claimed in order to preserve the appeal right of the provider.

The PRM does not specifically address the types of legal costs allowable under the Medicare program. We note that OMB Circular A-21 provides more specificity as to the type of legal related expenses which are unallowable (defense and prosecution of

criminal and civil proceedings, claims, appeals and patent infringements). We believe the PRM should be clarified to describe allowable legal costs and their relationship to patient care. Furthermore, since we are recommending that fines and penalties not be allowed (see below), we are also recommending that the legal costs associated with them not be allowed.

Consultants

At nine providers we found unallowable costs related to consultants retained for public relations, advertisement, real estate, and reimbursement matters. For example, one provider included consultant fees of \$60,000 related to the development of a plan to expand the provider's growth share within the health care industry. In our opinion, these costs are unallowable since they were incurred to increase patient utilization of the provider's facilities (the PRM relates this intent to unallowable advertising expense). In responding to our audit report, the provider stated that:

...it believes that this is an appropriate and allowable expenditure, however, the Medicare regulations are not clear regarding the treatment of an expenditure of this type. Because of this, the provider has decided to remove this cost from the Medicare Cost Report.

One provider retained a consultant to reopen prior years Medicare costs reports and to identify additional reimbursement due the provider. This consultant's fees of \$36,674 were based on a percentage of the additional reimbursement found. Although not specifically disallowed in the PRM, the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) section 109, prohibits a Medicare provider paid on a cost or cost related basis, recognition of any costs incurred by the provider under a contract where the payment is based on a percentage, or other proportion, of the provider's charges, revenues or claim for reimbursement. The provider did not comment on our conclusion that these costs were unallowable.

The PRM does not directly address the issue of consultants. We believe that the PRM should be revised to clarify the treatment of consultant costs.

Fines and Penalties

At seven providers we found unallowable costs for fines and penalties resulting from violations of Federal and local laws and regulations. For example, one hospital charged \$6,243 for Internal Revenue Service penalties and interest related to a quarterly Federal tax return. This provider contended the costs were allowable because they:

...related to patient care in so far as compliance with federal laws. Failure to comply with the government's action would result in heightened operating expenses.

Other fines and penalties included on Medicare cost reports were not related to taxes. For example, one provider included fines and penalties amounting to \$6,035 for various local fire code violations and payment of parking tickets received by staff members. The provider agreed that these costs were not allowable for Medicare reimbursement. Another provider took a different view. This provider argued that a fine of \$2,500 imposed by the local health department was allowable because it was not related to taxes and, therefore, not covered by the PRM.

The above provider was making reference to the fact that the PRM does not have a separate section on fines and penalties. Under section 2122.1 on taxes, however, it is mentioned that tax expenses should not include fines and penalties. We note that OMB Circular A-21 has a separate section on fines and penalties. We believe that the PRM should have one also. Further, HCFA should make it clear that any interest on fines and penalties is likewise allowable.

Physician Support and Recruitment Costs

At four providers we found unallowable costs relating to physician support and recruitment. Three of these providers included these costs on the Medicare cost reports. The fourth provider believed that these costs were unallowable for Medicare reimbursement and, therefore, did not include these costs on the Medicare cost report. Most of the unallowable costs--\$1.8 million--were found on the Medicare cost report of one hospital. This hospital included the costs of:

- assisting new physicians in establishing their practices;
- recruitment and incentive payments made to physicians; and
- payments to practicing physicians for office subsidies, office construction, parking, meals, promotional activities and marketing consultants.

Although the hospital agreed that a portion of these costs were unallowable and were inadvertently included in the Medicare costs report, it went on to state that:

...we believe that many of the expenses in the "physician support" area may be allowable.

The hospital which did not include these costs stated that:

...the hospital self-disallowed these costs in compliance with the PRM.

The PRM does not currently address the issue of physician recruitment and support. Therefore, the decision to claim these costs is left up to the individual hospital based on the hospital's determination if the costs are related to patient care. As shown above, this

is a difference of opinion among providers surrounding the allowability of these costs. We believe that the PRM should specifically address these costs.

Self-Insurance Reserves

At two hospitals we found unallowable costs for self-insurance reserves that were not established in accordance with provisions of the PRM. One hospital accrued \$15 million as a self-insurance reserve for retirees' health insurance benefits. The other hospital established a \$15 million reserve to self-insure itself against malpractice losses. The fund paid out \$4.4 million. Consequently, the provider overstated its malpractice costs by \$10.6 million in its efforts to fund the reserve fund.

Section 2162.7 of the PRM states that a hospital is required to establish its self-insurance fund with a recognized independent fiduciary, such as a bank, trust company, or private benefit administrator. The provider and fiduciary must enter into a written agreement which addresses conditions, including (1) legal responsibilities and obligations required by State laws; (2) legal title to the fund and responsibility for proper administration, and control rests with the fiduciary; (3) payments by the fiduciary; (4) termination from the Medicare program; and (5) reporting.

The hospital that established the self-insurance reserve for retirees' health insurance benefits responded that the reserve is not clearly unallowable under the Medicare program. The hospital stated that the expense was recorded in response to the Financial Accounting Standards Board (FASB) issuance in December 1990, Statement Number 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions," and that it is not a self-insurance reserve. According to the provider, it is one of the first to deal with this issue, and HCFA does not have regulations which clearly state how the costs of the post-retirement benefits accrued liabilities should be treated on Medicare cost reports.

We believe that the PRM should be revised to incorporate the issue involving FASB Statement Number 106. In this regard, on March 30, 1993, the OIG issued to HCFA a report entitled, "Implementation of Financial Accounting Standards Board Statement Number 106, Entitled Employers Accounting for Postretirement Benefits Other Than Pensions" (A-01-92-00520).

Miscellaneous Costs

At 13 providers we found numerous unallowable costs that were not related to any of the above cost categories. These miscellaneous costs were incurred for items such as photography work (\$39,966), insurance on art work (\$10,082), condominium rental (\$9,452), birth announcements (\$8,160), physician gifts (\$5,407), and lobbying (\$4,222).

The responses from the providers on the miscellaneous costs items were mixed. A number of providers agreed that the costs were unallowable, yet other providers felt that the costs were related to patient care and, therefore, allowable.

Costs of this nature are not specifically addressed in the PRM. The providers must rely on their interpretation of the three basic cost concepts--reasonableness, relationship to patient care, and the "Prudent Buyer" concept to judge the allowability of these miscellaneous items. We believe that the PRM should be revised to provide a comprehensive list of miscellaneous costs that are not allowed.

Conclusions and Recommendations

Although the results of our review are not representative of the operations of the 21 providers included in the review, the results do demonstrate a need for more explicit guidelines on the allowability of certain G&A and FB costs charged to the Medicare program. Many of the costs we identified in our review as being unallowable were clearly unallowable and caused by the providers' lack of adequate internal controls. Other unallowable costs and the costs that we have labeled as "costs for concern" appear to result from varying interpretations of cost concepts included in the PRM.

We recognize that the impact of the unallowable and otherwise questionable costs on the Medicare program is reduced by the fact that the majority of participating hospitals are paid under a fixed price system--PPS. We believe, however, that there remains a need for HCFA to revise the PRM to provide explicit guidelines on the allowability of certain G&A and FB costs. There appears to be too much reliance placed on the broadly defined cost concepts of reasonableness, relationship to patient care, and the "Prudent Buyer" concept, without explicit instructions on how these concepts should be applied to specific G&A and FB costs.

The PRM is not alone in this regard. The OMB has recently revised OMB Circular A-21 to clarify the allowability of costs charged by colleges and universities. We believe that HCFA should take similar action to revise the PRM.

We, therefore, recommend that HCFA revise the PRM to make it as consistent as possible with the cost provisions contained in OMB Circular A-21, giving full consideration to the information provided in this report and the fact that costs to be allowable must be related to patient care. Specifically, HCFA should:

1. Clarify when costs are necessary for the overall operation of an institution and when the costs relate to patient care.
2. Clarify the relationship between employee benefits and/or perquisites to entertainment and to patient care.

The HCFA comments have been summarized and incorporated in this report, and are included in their entirety as Appendix B.

We believe that an in-depth study of the issues raised in this report is a positive step toward making the required changes to the PRM. In its study, HCFA should consider each of the recommendations included in this report. The OIG is willing to provide assistance to HCFA in developing criteria on allowable costs.

The HCFA stated that, after an in-depth review of the issues raised in this report, as well as a report issued by GAO, it will revise the PRM, as appropriate, to address specific categories of G&A and FB costs in order to provide better guidance to hospitals, other providers, and intermediaries concerning the allowability of the costs.

The HCFA readily agreed that certain costs such as those costs associated with alcoholic beverages, provider lobbying, and charitable contributions were unallowable. However, HCFA also stated that costs related to subsidized employee meals and employee awards were allowable.

HCFA Response and OIG Comments

3. Specify that cost of entertainment, goods or services for personnel use, alcohol, all fines and penalties and associated interest, dues, and membership costs associated with civic and community organizations are unallowable.
4. Clarify the distinction between advertising costs and donations and the types of advertising and public relations costs that are allowable. Specify that all donations are unallowable costs.
5. Clarify the allowability of legal costs, consultant costs, physician support, and recruitment costs.
6. Clarify the allowability and accountability of employees postretirement benefits as recommended in our March 1993 OIG report (A-01-92-00520).
7. Provide a comprehensive list of unallowable miscellaneous type costs.

APPENDICES

APPENDIX A

REGION	HOSPITAL SELECTED FOR REVIEW	TYPE	CIN
I	Massachusetts General Hospital-Boston, MA New England Medical Center-Boston, MA	Non Profit/PPS	A-01-92-00510 A-01-92-00511
II	Beth Israel-New York, NY Lenox Hill Hospital-New York, NY	Non Profit/PPS	A-02-92-01023 A-02-92-01022
III	Medical College of Pennsylvania-Philadelphia, PA Thomas Jefferson University Hospital-Philadelphia, PA Albert Einstein Medical Center-Philadelphia, PA Moss Rehabilitation Center-Philadelphia, PA Allied Services Management-Home Office-Scranton, PA Allied Services Institute-Scranton, PA The John Heinz Institute-Scranton, PA	Non Profit/PPS Non Profit/PPS Non Profit/PPS Non Profit/PPS Non Profit/TFRA Non Profit/TFRA Non Profit/TFRA	A-03-92-00015 A-03-92-00016 A-03-92-00005 A-03-92-00006 A-03-92-00008 A-03-92-00008 A-03-92-00008
IV	Humana Incorporated-Louisville, KY Baptist Hospital-Miami, FL Parkway Hospital-Miami, FL	Profit/PPS Non Profit/PPS Profit/PPS	A-04-92-02034 A-04-92-02043 A-04-92-02042
V	Northwestern Memorial Hospital-Chicago, IL Memorial Medical Center-Springfield, IL	Non Profit/PPS Non Profit/PPS	A-05-92-00054 A-05-92-00058
VI	Humana Hospital-San Antonio, TX	Profit/PPS	A-06-92-00072
VII	North Kansas City Hospital-North Kansas City, MO St. Joseph Hospital-Denver, CO	Non Profit/PPS Non Profit/PPS	A-07-92-00554 A-07-92-00555
IX	Roseville Hospital-Roseville, CA	Non Profit/PPS	A-09-92-00068
X	Virginia Mason Hospital-Seattle, WA	Non Profit/PPS	A-10-92-00008

* City Owned

SUMMARY

2 Home Office Cost Reports(1 Non Profit & 1 For Profit)
19 Hospital Cost Reports(17 Non Profit & 2 For Profit)
21 Cost Reports

The Administrator
Washington, D.C. 20201

JAN 26 1994

Bruce C. Vladeck
Administrator

FROM:

Office of Inspector General (OIG) Draft Audit Report: "National Review of General and Administrative and Fringe Benefit Costs at Hospitals" (A-03-92-00017)

SUBJECT:

June Gibbs Brown
Inspector General

TO:

We have reviewed the subject draft report which summarizes the results of the OIG's review of selected general and administrative (G&A) costs and fringe benefit (FB) costs contained in Medicare hospital cost reports.

Medicare payment principles are designed to recognize as provider costs all necessary and proper costs incurred in rendering services to Medicare beneficiaries. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. Implicit in the intention that only reasonable costs be recognized is the expectation that a provider will seek to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer would pay.

HCFR is considering the issues identified in this audit. OIG's findings identify some G&A and FB costs, such as alcoholic beverages at employee functions, provider lobbying costs, and charitable contributions made by providers, that we agree do not constitute allowable costs. We believe that some other costs identified in the report, such as subsidized employee meals and employee awards, are allowable. However, we plan to make an in-depth analysis of the report. Based on our analysis of OIG's findings and the similar findings of a separate report prepared by the General Accounting Office, we will revise the Provider Reimbursement Manual, as appropriate, to address specific categories of G&A and FB costs in order to provide better guidance to hospitals, as well as other providers and intermediaries, concerning the allowability of these costs.

Thank you for the opportunity to review and comment on this draft report. Please advise us if you would like to discuss our position on the report recommendation at your earliest convenience.

~~Log #275~~

Brenda James

To: Libby Powers
Cc: Jeff Saxon
Subject: RE: Log Letter # 000275

OK, thanks, bj

Brenda James
Administrative Coordinator I
JAMESBR@scdhhs.gov
803.898.2580
www.scdhhs.gov



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From: Libby Powers
Sent: Tuesday, February 25, 2014 10:17 AM
To: Brenda James
Cc: Jeff Saxon
Subject: Log Letter # 000275

Brenda,

Can we please get an extension on this log letter. It should be completed by Friday, 2/28/14.

Thank you.

Libby Powers
Administrative Coordinator
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March 21, 2014

Ms. Sherry J. Finlayson, Director of Reimbursement
Conway Medical Center
300 Singleton Ridge Road
P.O. Box 829
Conway, S.C. 29528-0829

Dear Ms. Finlayson:

I am writing in response to your February 3, 2014 letter, which requested information relating to your hospital's appeal rights under the South Carolina Medicaid Program. Specifically, your hospital wishes to protect its appeal rights relating to a Myers and Stauffer audit adjustment which disallowed physician recruitment expenses that impacted your hospital's fiscal year end September 30, 2006 Medicaid cost report audit settlement.

The Department conducted its own research of the cost in question via review of the Provider Reimbursement Manual and Attachment 4.19-A of the South Carolina Medicaid State Plan to determine whether the physician recruitment expenses would be considered an allowable cost for South Carolina Medicaid hospital reimbursement purposes. Based upon our research of the information presented in your letter, we agree with Myers and Stauffer that the subject cost is not reimbursable under the South Carolina Medicaid Hospital Reimbursement Program. Our conclusion is primarily based upon the following:

- South Carolina allowable Medicaid reimbursable costs associated with the provision of inpatient and outpatient hospital services exclude costs that are associated with the rendering and billing of professional services. Professional services rendered by physicians in either an inpatient or outpatient hospital setting are reimbursed through the South Carolina Medicaid Physician Reimbursement Program.
- The audit adjustment references income guarantees to physician practices that require the physicians to fulfill performance requirements so that their loans will be forgiven. From this description of the adjustment, it appears that the physician recruitment expense is associated with the operation of a physician practice, whether privately owned or owned by a hospital. Physician practices operated under a hospital umbrella are treated as a non-reimbursable cost center for South Carolina Medicaid hospital cost reporting purposes.

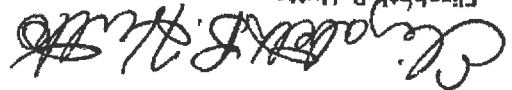
If you disagree with this determination and wish to pursue an appeal, please direct your appeal request to the Division of Appeals, South Carolina Department of Health and Human Services, P.O. Box 8206, Columbia, S.C. 29202-8206. Your appeal request should include a copy of the disallowance notice, a copy of this letter, and the reasons you feel that the Department's determination was incorrect. In general, parties must appeal a Department decision within 30 days. However, Conway Medical Center has been

Ms. Finlayson
March 21, 2014
Page 2 of 2

engaged in seeking timely assistance from the Department and has good cause for being outside of the 30 day window. Your hospital's appeal rights are contained within your South Carolina Medicaid hospital contract.

If you should have any questions, please contact Mr. Jeff Saxon at (803) 898-1023.

Sincerely,



Elizabeth B. Hutto

Interim Deputy Director

Office of Finance and Administration

EBH/lp

cc: Jeff Saxon

Robert French