



AUG 13 2001

**Memorandum**

Date *Michael Mangano*  
From Michael F. Mangano  
Principal Deputy Inspector General

Subject Review of Mutual of Omaha's Oversight of Medicare Inpatient Acute Care Providers  
Receiving Periodic Interim Payments (A-07-01-02616)

To Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services

Attached are two copies of our final report entitled, "Review of Mutual of Omaha's Oversight of Medicare Inpatient Acute Care Providers Receiving Periodic Interim Payments." The objective of our review was to determine whether Mutual of Omaha (Mutual), during cost report settlement, had properly quantified interim Medicare payments made to providers receiving interim payments under the periodic interim payment (PIP) method. Inpatient acute care hospitals that are paid through PIP receive predetermined biweekly payments. In addition, other interim payments may include: (i) level payments, (ii) operating day outliers, (iii) operating cost outliers, (iv) capital outliers, (v) retroactive adjustments, and (vi) Medicare secondary payer claims. For discharges after September 30, 1997, day outliers were eliminated.

We found that Mutual did not always properly quantify interim payments for prospective payment system (PPS) hospital providers. Mutual omitted outlier payments from interim payments for five of eight providers' cost reports we reviewed. As a result, Mutual overpaid five PPS hospitals a total of \$636,867 based on their settled cost reports. The overpayments resulted from the omission of outliers from a worksheet used to determine interim payments made to a PIP provider.

Our draft report indicated the possibility that Medicare overpayments could be substantially more since Mutual had about 100 providers on PIP which received outlier payments. Subsequently, Mutual performed a comprehensive review of settled cost reports for PIP providers and found that total overpayments were about \$10.8 million, of which \$10.7 million is collectible. Further, there is a possibility that the omission of outliers in determining total interim payments occurred at other fiscal intermediaries (FI). During 1998, there were over 1,000 hospitals nationwide receiving PIP.

In our draft report, we recommended that the Centers for Medicare and Medicaid Services (CMS) monitor Mutual's collection of overpayments for the five providers identified in our review, monitor Mutual's reopening of cost reports and collection of overpayments made in the past, direct Mutual to implement procedures to ensure that future

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cost report settlements include the proper calculation of interim payments, and work with the Office of Inspector General (OIG) to determine whether interim payments made to PIP providers at other FIs were calculated correctly at final settlement.

In response to our draft report, CMS concurred with our recommendations and is monitoring Mutual's collection of overpayments. The CMS has also directed Mutual to implement procedures to ensure that future cost report settlements appropriately account for all interim payments. Additionally, CMS has sent an instruction to all FIs that requires them to sample their PIP hospital cost reports to ensure that interim payment calculations were correct at cost report settlement. We are pleased with CMS's actions, and continue to recommend that CMS work with OIG to determine whether interim payments made to PIP providers at other FIs were calculated correctly at final settlement.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-07-01-02616 in all correspondence relating to this report.

Attachments

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MUTUAL OF OMAHA'S  
OVERSIGHT OF MEDICARE INPATIENT  
ACUTE CARE PROVIDERS RECEIVING  
PERIODIC INTERIM PAYMENTS**



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Principal Deputy Inspector General

Subject Review of Mutual of Omaha's Oversight of Medicare Inpatient Acute Care Providers  
Receiving Periodic Interim Payments (A-07-01-02616)

To Thomas Scully  
Administrator  
Centers for Medicare and Medicaid Services

This final report provides the results of our review of the settlement of cost reports by Mutual of Omaha (Mutual) for Medicare inpatient acute care providers receiving interim payments under the periodic interim payment (PIP) reimbursement method.

The objective of our review was to determine whether Mutual, during cost report settlement, had properly quantified interim Medicare payments made to providers receiving payments under the PIP method. We found that Mutual did not always properly quantify interim payments for prospective payment system (PPS) hospital providers. Mutual omitted outlier payments from interim payments for five of eight providers' cost reports we reviewed. As a result, these providers were overpaid.

Mutual overpaid five of eight PPS hospitals a total of \$636,867 based on their settled cost reports. The overpayments resulted from the omission of outliers from a worksheet used to determine interim payments made to a PIP provider. These interim payments are subtracted from the total reimbursement owed to determine the amount due to, or from, a provider. In other words, an understatement of interim payments results in a Medicare overpayment. We brought this to Mutual's attention and worked with Mutual to verify the overpayments.

Our draft report indicated the possibility that Medicare overpayments could be substantially more since Mutual had about 100 providers on PIP which received outlier payments. Subsequently, Mutual performed a comprehensive review of settled cost reports for PIP providers and found that total overpayments were about \$10.8 million, of which \$10.7 million is collectible. Further, there is a possibility that the omission of outliers in determining total interim payments occurred at other fiscal intermediaries (FI). During 1998, there were over 1,000 hospitals nationwide receiving PIP.

In our draft report, we recommended that the Centers for Medicare and Medicaid Services (CMS): (i) monitor Mutual's collection of overpayments for the five providers identified in our review; (ii) monitor Mutual's reopening of cost reports and collection of overpayments made in the past; (iii) direct Mutual to implement procedures to ensure that

future cost report settlements include the proper calculation of interim payments; and (iv) work with the Office of Inspector General (OIG) to determine whether interim payments made to PIP providers at other FIs were calculated correctly at final settlement.

In response to our draft report, CMS concurred with our recommendations and is monitoring Mutual's collection of overpayments. The CMS has also directed Mutual to implement procedures to ensure that future cost report settlements appropriately account for all interim payments. Additionally, CMS has sent an instruction to all FIs that requires them to sample their PIP hospital cost reports to ensure that interim payment calculations were correct at cost report settlement. We are pleased with CMS' actions, and continue to recommend that CMS work with OIG to determine whether interim payments made to PIP providers at other FIs were calculated correctly at final settlement. The CMS response is attached to this report as the Appendix. The CMS also made some technical comments which we incorporated into this final report.

## **BACKGROUND**

In 1983, the Congress enacted Public Law 98-21 which authorized the Medicare PPS effective October 1, 1983. Under PPS, acute care hospitals are reimbursed for each admission at the time of patient discharge, according to individual patient diagnoses which are categorized into diagnostic related groups codes.

Inpatient acute care hospitals are reimbursed for inpatient stays in one of two ways:

on the basis of actual claims submitted by hospitals to the FI , or

on the basis of PIP.

Inpatient acute care hospitals that are paid based on actual claims are paid by a remittance advice showing the net difference between the amount of the payment requested and any adjustments.

According to the criteria in 42 CFR 412.116, for PPS inpatient services furnished since July 1987, a hospital can only receive PIP payments if it received PIP payments on June 30, 1987 and (1) the FI failed to make prompt payments, or (2) the hospital had a disproportionate share payment adjustment of at least 5.1 percent, or (3) the hospital was located in a rural area and had 100 or fewer beds. In addition, to receive PIP payments the hospital must meet the criteria in 42 CFR 413.64(h); specifically, (1) total Medicare payment for inpatient services computed under the method is at least \$25,000 on an annual basis, (2) the hospital has filed with its FI at least one completed cost report under the Medicare program, and (3) the FI is assured that the hospital has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report.

Inpatient acute care hospitals that are reimbursed through PIP receive predetermined biweekly payments. In addition, other interim payments may include: (i) level payments, (ii) operating day outliers, (iii) operating cost outliers, (iv) capital outliers, (v) retroactive adjustments, and (vi) Medicare secondary payer claims. For discharges after September 30, 1997, day outliers were eliminated.

As part of the cost report settlement process at the end of the provider's fiscal year, the FI compares the reimbursement owed to a hospital to the interim payments made and determines whether the hospital is owed additional funds or must refund some portion of the interim payments. Obviously, care needs to be taken to ensure the sum of all interim payments is correctly stated. If the sum of the interim payments is understated for any reason, the provider will be overpaid.

## **SCOPE**

The objective of our review was to determine whether Mutual, during cost report settlement, properly quantified interim payments received by inpatient acute care providers paid under the PIP method. We performed a limited scope review based on PIP provider cost reports ending in Calendar Year 1997 which had been settled by Mutual, the FI.

Mutual provided us with a listing of PIP providers compiled during 1998, from which we judgmentally selected 34 cost reports that had been settled during Federal Fiscal Year 1999. We reviewed 17 cost reports, of which 4 were not PIP providers during 1997. Of the remaining 13 cost reports reviewed, only 8 were for PPS inpatient acute care hospital providers which received PIP payments. Three cost reports were for non-PPS hospitals, one cost report was for a skilled nursing facility, and one cost report was for a home health agency.

## **FINDINGS AND RECOMMENDATIONS**

Three of the eight providers were paid correctly. We found that five of eight PPS hospital PIP providers received Medicare overpayments totaling \$636,867 due to Mutual's omission of outlier payments from interim payments during the cost report settlement process. We believed overpayments resulting from this omission at cost report settlement could be substantial since Mutual had about 100 providers on PIP which also had outlier payments. Additionally, if this problem exists at other FIs, there may have been Medicare overpayments totaling several million dollars. Mutual officials agreed with our findings. Mutual reopened cost reports, identified previous overpayments, and implemented training procedures to prevent similar miscalculations in the future. Mutual determined all PPS hospitals which received a PIP payment in Calendar Years 1996, 1997, and 1998 and reopened the settled reports, reviewed Part A interim payment calculations, and issued Notices of Correction of Program Reimbursement or Notices of Closure, as necessary.

Mutual determined 60 hospitals were overpaid approximately \$14.4 million in Medicare overpayments. However, Mutual found 21 hospitals were underpaid about \$3.6 million. Additionally, overpayments of about \$100,000 were no longer collectible because the provider had terminated its participation in the program, or the provider was bankrupt. Consequently, Mutual had net overpayments of about \$10.7 million collectible for the Medicare program.

### Outlier Payments

Mutual did not always include outlier payments in interim payments when cost reports were audited and settled. As part of the cost report settlement process at the end of the provider's fiscal year, the FI subtracts interim payments from the reimbursement owed to a provider to determine whether the hospital was overpaid or underpaid. Since outlier payments were not always included in interim payments, some providers received Medicare overpayments.

As of March 27, 1996, Mutual internally developed a worksheet for its audit staff to determine the interim payments paid to a PIP provider. The worksheet included the following items: (i) PIP and level payments, (ii) day and cost outliers, (iii) Medicare secondary payer, and (iv) retroactive adjustments and overpayments. This form was modified on March 11, 1998 to change the day and cost outliers line item to two line items, one for operating day and cost outliers, another for capital outliers. The proper completion of the worksheet should have resulted in the correct determination of total payments for cost report settlement.

However, we found that the worksheet was not always properly completed. We found that Mutual had not included the total outliers in interim payments in the final settlement process for five of the eight PPS hospital cost reports we reviewed. For two hospitals, all outliers were omitted from interim payments. For two hospitals, cost and capital outliers were omitted from interim payments. For another, only the capital outlier was omitted from interim payments. We also found that Mutual had made a computation error of the interim level payments made to one provider which reduced its Medicare overpayment. The overpaid providers were:

<u>Provider Name</u>	<u>Medicare Overpayment</u>	<u>Outlier(s) Omitted</u>
Monroe County Hospital	\$ 18,109	Day, Cost, Capital
Pacific Alliance Medical Center	24,348	Day, Cost, Capital
Pacific Hospital of Long Beach	3,571	Cost, Capital
Franklin Foundation Hospital	57,065	Cost, Capital
University of Pennsylvania	<u>533,774<sup>1</sup></u>	Capital
<b>TOTAL</b>	<b><u>\$636,867</u></b>	

<sup>1</sup>Our audit showed that the gross overpayment (as a result of omitted capital outliers) was \$637,374. We also found an unrelated error which reduced the gross overpayment by \$103,600. The net overpayment was \$533,774.

Due to the omission of outliers from computations of interim payments, the Medicare program overpaid these five providers by \$636,867. We estimated that the Medicare program may have made overpayments totaling several million dollars, since there were approximately 100 PPS hospital providers serviced by Mutual during the period sampled. Furthermore, there may be overpayments of several million dollars at other FIs, since there are over 1,000 PIP hospital providers nationwide.

Mutual officials indicated the primary reason that outlier payments had not been included on the worksheet was a lack of training of audit staff in the proper completion of the form.

Mutual officials agreed with our findings and reopened cost reports to recover previous overpayments. Mutual performed a comprehensive review of settled cost reports for PIP providers and found that total overpayments were about \$10.8 million, of which \$10.7 million is collectible. Also, Mutual has provided training to audit staff to help ensure that outlier payments are included during future cost settlements.

### **Recommendations**

We recommend that CMS:

1. Monitor Mutual's collection of overpayments for the five providers identified in our review (\$636,867).
2. Monitor Mutual's collection of the overpayments identified in its review (\$10.7 million).
3. Direct Mutual to implement procedures to ensure that future cost report settlements include the proper calculation of total payments.
4. Work with OIG to determine whether interim payments made to PIP providers at other FIs were calculated correctly at final settlement.

### **CMS' COMMENTS**

The CMS concurred with our recommendations and is monitoring Mutual's collection of overpayments. The CMS has also directed Mutual to implement procedures to ensure that future cost report settlements appropriately account for all interim payments. Additionally, CMS has sent an instruction to all FIs that requires them to sample their PIP hospital cost reports to ensure that interim payment calculations were correct at cost report settlement.

**OIG'S RESPONSE**

We are pleased with CMS' actions, and continue to recommend that CMS work with OIG to determine whether interim payments made to PIP providers at other FIs were calculated correctly at final settlement.



DATE: JUN 21 2001

TO: Michael F. Mangano  
Acting Inspector General

FROM: — Michael McMullan   
Acting Deputy Administrator  
Health Care Financing Administration

SUBJECT: Office of Inspector General (OIG) Draft Report: *Review of Mutual of Omaha's Oversight of Medicare Inpatient Acute Care Providers Receiving Periodic Interim Payments (A-07-01-02616)*

Thank you for the opportunity to review the above-referenced OIG draft report concerning Mutual of Omaha's (Mutual) oversight of Medicare inpatient acute care providers receiving periodic interim payments (PIPs). The OIG found that Mutual did not always properly quantify interim payments for prospective payment system (PPS) hospital providers. The Health Care Financing Administration (HCFA) is concerned about these findings. We have taken steps to ensure that Mutual corrects its cost report settlement process for PIP providers and to assess the process at other fiscal intermediaries (FIs) in order to determine if the problem is widespread.

OIG recommends that HCFA do the following:

OIG Recommendation 1:

HCFA should monitor Mutual's collection of overpayments for the five providers identified in the OIG review.

OIG Recommendation 2:

HCFA should monitor Mutual's reopening of the cost reports and collection of overpayments made in the past.

OIG Recommendation 3:

HCFA should direct Mutual to implement procedures to ensure that future cost-report settlements include the proper calculation of interim payments.

HCFA Response 1, 2, and 3:

We concur with all three recommendations. The Kansas City Regional Office (RO) will lead the effort to monitor improvements at Mutual. The RO will monitor collection of overpayments for the five cost reports that OIG determined were settled in error. The RO

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is overseeing Mutual's review of interim payment calculations for all inpatient acute care PIP providers for all cost-reports that can be reopened. The RO has also directed Mutual to implement procedures to ensure that future cost-report settlements appropriately account for all interim payments.

OIG Recommendation 4:

HCFA should work with OIG to determine whether interim payments made to PIP providers at other fiscal intermediaries (FIs) were calculated correctly at final settlement.

HCFA Response 4:

We concur. We recently sent an instruction to all FIs that requires them to sample their PIP hospital cost reports to ensure that interim payment calculations were correct at cost-report settlement. Upon completion of the analysis, each FI will send in a report to HCFA. In addition, we have instructed the FIs to submit to HCFA their procedures for calculation of interim payments at cost report settlement. We would be glad to share these reports with OIG so that we can work together to ensure that interim payments are correctly accounted for by all of our FIs when settling cost reports.

Attached are technical comments on the draft report.

Attachment