



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



June 28, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance (A-07-10-02764)

The attached final report provides the results of our review of the reconciliation process for outlier payments under the Medicare Part A prospective payment system.

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If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-07-10-02764 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE CENTERS FOR MEDICARE
& MEDICAID SERVICES
DID NOT RECONCILE
MEDICARE OUTLIER PAYMENTS
IN ACCORDANCE WITH FEDERAL
REGULATIONS AND GUIDANCE**



Daniel R. Levinson
Inspector General

June 2012
A-07-10-02764

Office of Inspector General

<http://oig.hhs.gov>

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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

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) uses a prospective payment system (PPS) to pay Medicare-participating hospitals (hospitals) for providing inpatient hospital services to Medicare beneficiaries. Under the PPS, CMS adjusts basic prospective payments for unusually high costs. These additional payments, known as outlier payments, are designed to protect hospitals from excessive losses due to unusually high-cost cases. CMS has historically projected outlier payments to be 5.1 percent of total basic prospective payments. To allow for these outlier payments, CMS reduced basic prospective payments by 5.1 percent. From Federal fiscal year (FY) 1998 through FY 2002, CMS's total outlier payments exceeded 5.1 percent. As a result, CMS paid hospitals approximately \$9 billion more in outlier payments than the \$17.6 billion that it had intended. CMS stated that some hospitals had taken advantage of vulnerabilities in the outlier payment methodology to maximize their outlier payments. These vulnerabilities allowed some cases to qualify as outliers when, in actuality, they were not unusually high-cost cases.

In 2003, CMS developed new regulations that revised the outlier payment methodology to address these vulnerabilities. Our review focused on one of these revisions: the requirement to reconcile outlier payments before the settlement of hospital cost reports to ensure that these payments accurately reflect the actual costs incurred by the hospital.

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers Medicare and uses a PPS to pay hospitals for providing inpatient hospital services to Medicare beneficiaries. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.

Section 1886(d)(5)(A) of the Act allows Medicare to supplement basic prospective payments for inpatient hospital services by making outlier payments for unusually high-cost cases. To qualify for outlier payments, a case must have estimated costs that exceed a CMS-established cost threshold. Costs are calculated by multiplying covered charges by a hospital-specific cost-to-charge ratio (CCR).

CMS and the Office of Inspector General have previously determined that some hospitals dramatically increased charges in an effort to inappropriately maximize outlier reimbursement. Accordingly, CMS implemented new inpatient outlier regulations in 2003. These regulations address Medicare vulnerabilities and mandate that outlier payments to hospitals that rapidly increase charges are subject to reconciliation of outlier payments (reconciliation) to (1) correctly reprice submitted claims and (2) allow Medicare contractors to settle cost reports. Under these regulations, as well as additional guidance that CMS issued in 2005, Medicare contractors are to refer hospitals' cost reports to CMS (through a process that we will refer to as "cost report referral") for reconciliation of outlier payments. In December 2010, CMS stated that it had not performed reconciliations because of system limitations. CMS directed Medicare contractors to

perform the reconciliations (of both new outlier payments that qualified for reconciliation and outlier payments whose reconciliations have been backlogged since 2005) as of April 1, 2011.

For this audit we reviewed outlier cost report data submitted to CMS by 9 selected Medicare contractors that served a total of 15 jurisdictions during our audit period (October 1, 2003, through December 31, 2008). To allow for processing time for cost reports submitted by hospitals to Medicare contractors at the end of our audit period, we also reviewed relevant CMS policies and regulations through December 31, 2010.

OBJECTIVE

Our objective was to determine whether CMS reconciled outlier payments in accordance with Federal regulations and guidance.

SUMMARY OF FINDINGS

Contrary to Federal regulations and guidance, CMS did not reconcile outlier payments associated with 292 of the 305 cost reports that were referred to it by the 9 selected Medicare contractors. As a result, the Medicare contractors did not reach final settlement of the 292 cost reports. For the 13 remaining cost reports, CMS evaluated information submitted by the Medicare contractors and correctly determined that reconciliations of outlier payments were not required.

Because CMS did not reconcile the outlier payments, Medicare contractors were unable to reach final settlement of 292 cost reports as of the conclusion of our fieldwork. Payments were due from hospitals to Medicare for 236 of the 292 cost reports, and payments were due from Medicare to hospitals for the other 56 cost reports. The delayed payments to Medicare, along with associated interest, represent funds that should have been returned to the Medicare Trust Fund. At the same time, the delayed processing of outlier payments due from Medicare to hospitals, along with associated interest, could have affected those hospitals' financial viability. In addition, Medicare lost the interest that stopped accruing once the Medicare contractors referred the cost reports to CMS for reconciliation of outlier payments.

We identified two reasons why CMS did not perform the reconciliations. As of the end of our fieldwork, CMS had not developed and implemented an automated system to recalculate outlier claims using actual CCRs without adversely affecting other data. And even if CMS had developed and implemented an automated system by the end of our fieldwork, it would not have performed all of the reconciliations because it did not maintain a complete list of cost reports referred by the Medicare contractors. Although our review identified 305 hospital cost reports submitted by the 9 selected Medicare contractors to CMS for reconciliation, CMS's records for the same Medicare contractors and time period listed only 269 cost reports.

RECOMMENDATIONS

We recommend that CMS:

- ensure that Medicare contractors reconcile outlier payments and perform final settlement on the 292 cost reports we reviewed in accordance with Federal regulations and guidance,
- ensure that Medicare contractors reconcile outlier payments and perform final settlement on all cost reports submitted after our audit period in accordance with Federal regulations and guidance,
- implement an automated system that will recalculate outlier claims to facilitate reconciliations, and
- work with the Medicare contractors to develop and maintain a complete and accurate list of the cost reports with outlier payments requiring reconciliation.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with all of our recommendations and described corrective actions that it had implemented or planned to implement.

CMS's comments appear in their entirety as the Appendix.

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INTRODUCTION

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) uses a prospective payment system (PPS) to pay Medicare-participating hospitals (hospitals) for providing inpatient hospital services to Medicare beneficiaries. Under the PPS, CMS adjusts basic prospective payments for unusually high costs. These additional payments, known as outlier payments, are designed to protect hospitals from excessive losses due to unusually high-cost cases. CMS has historically projected outlier payments to be 5.1 percent of total basic prospective payments. To allow for these outlier payments, CMS reduced basic prospective payments by 5.1 percent. From Federal fiscal year (FY) 1998 through FY 2002, CMS's total outlier payments exceeded 5.1 percent. As a result, CMS paid hospitals approximately \$9 billion more in outlier payments than the \$17.6 billion that it had intended. In the preamble to its Final Rule, CMS stated that some hospitals had taken advantage of vulnerabilities in the outlier payment methodology to maximize their outlier payments.¹ These vulnerabilities allowed some cases to qualify as outliers when, in actuality, they were not unusually high-cost cases.

In 2003, CMS developed new regulations that revised the outlier payment methodology to address these vulnerabilities. Our review focused on one of these revisions: the requirement to reconcile outlier payments before the settlement of hospital cost reports to ensure that these payments accurately reflect the actual costs incurred by the hospital.

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the program. Medicare Part A is a hospital insurance program that helps cover inpatient hospital services, skilled nursing facility services, hospice services, and home health care services. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.²

¹ CMS, *Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital [LTCH] Prospective Payment Systems* (the Final Rule), 68 Fed. Reg. 34494, 34496 (Jun. 9, 2003).

² Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

Hospital Outlier Payments, Medicare Cost Report Submission, and Settlement Process

CMS uses a PPS, established under section 1886(d) of the Act, to pay hospitals for providing inpatient hospital services to Medicare beneficiaries. Section 1886(d)(5)(A) of the Act allows Medicare to supplement basic prospective payments for inpatient hospital services by making outlier payments for unusually high-cost cases. Medicare contractors calculate outlier payments based on claim submissions made by hospitals.

To qualify for outlier payments, a case must have costs that exceed a CMS-established cost threshold. Costs are calculated by multiplying covered charges by a hospital-specific cost-to-charge ratio (CCR). Because a hospital's actual CCR for any given cost-reporting period cannot be known until final settlement of the cost report for that year, the Medicare contractors calculate and make outlier payments based on the most current information available when processing individual outlier claims. For discharges occurring on or after October 1, 2003, the CCR applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period (42 CFR § 412.84(i)(2)). More than one CCR can be used in a cost reporting period.

Hospitals must submit cost reports to Medicare contractors within 5 months after the end of the hospitals' FYs. The cost reports are based on the hospitals' financial and statistical records. Outlier payments are included in the hospitals' cost reports. CMS's *Provider Reimbursement Manual*, part 2, section 140, instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report.³ After accepting a cost report,⁴ the Medicare contractor completes its preliminary review and may issue a tentative settlement to the hospital. In general, Medicare contractors perform tentative settlements to make partial payments to hospitals owed Medicare funds (although in some cases a tentative settlement may result in a payment from a hospital to Medicare). This practice helps ensure that hospitals are not penalized because of the delays that can accompany final settlement process.

The Medicare contractor reviews the cost report and may audit it before final settlement. After auditing the cost report, the Medicare contractor incorporates necessary adjustments to identify reimbursable amounts and finalize Medicare reimbursements due from or to hospitals.⁵ The Medicare contractor then issues a Notice of Program Reimbursement (NPR) to the hospital. As the final settlement document, the NPR shows whether payment is owed to Medicare or to the hospital. The final settlement thus incorporates any audit adjustments the Medicare contractor may have made.

³ A Medicare contractor can either accept a submitted cost report or return it for additional information and resubmission.

⁴ Medicare contractors do not accept every submitted cost report on its initial submission. Medicare contractors can return cost reports to hospitals for correction, additional information, or other reasons.

⁵ Among other reasons, cost reports can be adjusted to reflect actual expenses incurred or to make allowances for recovery of expenses through sales or fees.

Federal regulations and CMS's *Medicare Claims Processing Manual* (Claims Processing Manual) require that under certain circumstances, outlier payments be reconciled so that submitted claims can be correctly repriced before final settlement. This reconciliation process was the principal focus of our review.

Centers for Medicare & Medicaid Services Changes in the Methodology for Reconciling Hospital Outlier Payments

CMS and the Office of Inspector General (OIG) have previously determined that some hospitals have dramatically increased charges in an effort to inappropriately maximize outlier reimbursement.⁶ CMS reported (in the preamble to the Final Rule) that, from FYs 1998 through 2002, it paid approximately \$9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.^{7, 8} CMS stated that some hospitals had taken advantage of two vulnerabilities in an effort to maximize their outlier payments. The first vulnerability was the timelag between the submission of current charges on a claim and calculation of the CCR taken from the most recent settled cost report. The second vulnerability was that some hospitals had increased their billed charges so far above costs that outlier payments were not always limited to unusually high-cost cases. The Final Rule was intended to address these vulnerabilities.

Use of Updated Cost-to-Charge Ratios

Before October 1, 2003, CMS used a hospital's most recent settled cost report to calculate CCRs. As a result, the covered charges on claims that hospitals submitted for payment during FY 2003 were converted to costs by applying a CCR that was usually based on FY 2000 cost reports. If the rate of increase in a hospital's charges since FY 2000 exceeded the rate of increase in a hospital's costs during that time, the hospital's CCR based on its FY 2000 cost report would have been too high. Thus, applying the CCR to FY 2003 charges would have overestimated the hospital's costs per case. Overestimating costs may have enabled some cases to qualify for outlier payments when they were not unusually high-cost cases.

To better ensure that outlier payments accurately reflect the actual costs that hospitals incur, CMS implemented the Final Rule to address the vulnerabilities in the outlier payment methodology mentioned above. For discharges on or after October 1, 2003, the CCR applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost-reporting period (42 CFR § 412.84(i)(2)). In the preamble to the Final Rule, CMS stated that it expected this regulation to reduce the timelag for updating the CCR by a year or more.

⁶ See (1) Preamble, Final Rule, 68 Fed. Reg. at 34496-98, and (2) OIG, *Audit of the Effectiveness of the Revised Medicare Outlier Payment Regulations for Inpatient Acute Care Hospitals*, A-07-04-04032, Sept. 9, 2005.

⁷ 68 Fed. Reg. at 34496.

⁸ CMS had projected approximately \$17.6 billion for Medicare IPPS outlier payments but made approximately \$26.6 billion in payments.

Outlier Payment Reconciliation

In the preamble to the Final Rule, CMS stated that reducing the timelag alone would not eliminate a hospital's opportunity to increase its charges at a faster rate than costs during a given year in an effort to maximize its outlier payments. To address this vulnerability, the Final Rule included new requirements that were intended to ensure that outlier payments were limited to unusually high-cost cases. These requirements were to ensure that when final outlier payments were made, they would accurately reflect the actual costs the hospital incurred. Pursuant to the Final Rule, as well as CMS Transmittal 707,⁹ Medicare contractors were to refer hospitals' cost reports to CMS (through a process we will refer to as "cost report referral") for reconciliation of outlier payments so it could correctly reprice submitted claims and allow Medicare contractors to settle cost reports.¹⁰

The Final Rule and CMS guidance specify that for discharges occurring on or after August 8, 2003, outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the hospital and the CCR calculated at final settlement of the cost reporting period during which the discharge occurred (42 CFR § 412.84(i)(4); see also CMS's Claims Processing Manual, chapter 3, § 20.1.2.5).

Reconciliation Process

The CCR calculated at final settlement of the cost report is the actual CCR for that cost reporting period. This may differ from the CCR from the most recently settled or most recently tentative settled cost report that was used to calculate individual outlier claim payments during the cost reporting period. After the end of the cost reporting period, the hospital compiles the cost report from which the actual CCR for that cost reporting period can be computed. If a hospital's total outlier payments during the cost reporting period exceed \$500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during that period to make outlier payments, the Medicare contractor must refer the hospital's cost report to CMS for reconciliation (Claims Processing Manual, chapter 3, § 20.1.2.5).

If the criteria for reconciliation are not met, the Medicare contractor finalizes the cost report and issues an NPR to the hospital. If these criteria are met, the Medicare contractor refers the cost report to CMS at both the central and regional levels.

Transmittal 707 provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until April 1,

⁹ CMS, "IPPS Outlier Reconciliation," Claims Processing Manual, Transmittal 707 (Change Request 3966; October 12, 2005).

¹⁰ Although CMS did not instruct Medicare contractors to refer hospitals in need of reconciliation until 2005, the instructions were applicable to cost reporting periods beginning on or after October 1, 2003. Moreover, CMS's instructions during this period changed the responsibility for the performance of reconciliations. CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003) instructed Medicare contractors to perform reconciliations. Later, Transmittal 707 specified that CMS would perform reconciliations.

2011. In CMS Transmittal 2111,¹¹ CMS directed the Medicare contractors to assume the responsibility to perform the reconciliations effective April 1, 2011, but the CMS Central Office would determine whether reconciliation would be performed. CMS also stated that it had not performed reconciliations because of system limitations. To process the backlog, CMS instructed Medicare contractors to submit to CMS, between April 1 and April 25, 2011, a list of hospitals that had been flagged for reconciliation before April 1, 2011. Further, CMS was to grant approval for Medicare contractors to perform reconciliations for those hospitals with open cost reports. Contractors were then to reconcile, by October 1, 2011, outlier claims that had been flagged before April 1, 2011.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether CMS reconciled outlier payments in accordance with Federal regulations and guidance.

Scope

Our audit covered Medicare outlier payments to hospitals for services rendered between October 1, 2003, and December 31, 2008.¹² We reviewed cost report data submitted to CMS by 9 selected Medicare contractors that served a total of 15 jurisdictions during our audit period.

We did not perform detailed tests of internal controls because our objective did not require us to do so.

We were unable to quantify the full financial effect of our findings because neither CMS nor the Medicare contractors can accurately determine final Medicare reimbursement due from or to hospitals until reconciliations of hospital outlier payments have been performed and all cost report adjustments have been incorporated.

We performed our fieldwork at nine selected Medicare contractors and CMS headquarters in Baltimore, Maryland.

¹¹ CMS, *Outlier Reconciliation and Other Outlier Manual Updates for IPPS, OPSS [Outpatient PPS], IRF [Inpatient Rehabilitation Facility] PPS, IPF [Inpatient Psychiatric Facility] PPS and LTCH PPS*, Medicare Claims Processing Manual; Transmittal 2111 (Change Request 7192; December 3, 2010).

¹² To allow for processing time for cost reports submitted by hospitals to Medicare contractors at the end of our audit period and to assist us in identifying the causes of our findings, we expanded our scope to include CMS policies and regulations through December 31, 2010. See the related discussion in “Methodology.”

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- obtained documentation from CMS regarding all Medicare Part A inpatient hospitals whose cost reports the Medicare contractors referred to CMS for reconciliation;
- obtained from the Medicare contractors a list of hospitals whose cost reports they referred to CMS and compared this list to the documentation that we obtained from CMS;
- compared cost report referral information with information that we obtained from CMS's Hospital Cost Report Information System (HCRIS) database;
- extracted HCRIS data to identify hospitals that received outlier payments in excess of \$400,000;¹³ and
- discussed the results of our review with CMS officials on August 3, 2011.

CMS's processing guidelines permit hospitals to submit their cost reports to the Medicare contractors up to 5 months after FY end. These guidelines also grant the Medicare contractors up to 30 days to accept each submitted cost report and, generally, an additional year to review it after acceptance. Thus, for cost reports with FY ends of December 31, 2008, we determined whether those cost reports were associated with outlier payments requiring reconciliation and then evaluated data through calendar year (CY) 2010 to determine whether reconciliations had been performed.¹⁴

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 objective.

FINDINGS AND RECOMMENDATIONS

Contrary to Federal regulations and guidance, CMS did not reconcile outlier payments associated with 292 of the 305 cost reports that were referred to it by the 9 selected Medicare contractors. As a result, the Medicare contractors did not reach final settlement of the 292 cost reports. For

¹³ Simultaneously with this review, we are performing reviews of the reconciliation process at the Medicare contractor level to determine whether the Medicare contractors conformed to Federal requirements in making cost report referrals to CMS. To ensure that we identified all cost reports that may have required reconciliation, we reviewed the cost reports for all hospitals that had received outlier payments in excess of \$400,000 during the cost reporting period.

¹⁴ Hospital FYs do not always coincide with Federal FYs.

the 13 remaining cost reports, CMS evaluated information submitted by the Medicare contractors and correctly determined that reconciliations of outlier payments were not required.

Because CMS did not reconcile the outlier payments, Medicare contractors were unable to reach final settlement of 292 cost reports as of the conclusion of our fieldwork. Payments were due from hospitals to Medicare for 236 of the 292 cost reports, and payments were due from Medicare to hospitals for the other 56 cost reports. The delayed payments to Medicare, along with associated interest, represent funds that should have been returned to the Medicare Trust Fund. At the same time, the delayed processing of outlier payments due from Medicare to hospitals, along with associated interest, could have affected those hospitals' financial viability. In addition, Medicare lost the interest that stopped accruing once the Medicare contractors referred the cost reports to CMS for reconciliation of outlier payments.

We identified two reasons why CMS did not perform the reconciliations. As of the end of our fieldwork, CMS had not developed and implemented an automated system to recalculate outlier claims using actual CCRs without adversely affecting other data. And even if CMS had developed and implemented an automated system by the end of our fieldwork, it would not have performed all of the reconciliations because it did not maintain a complete list of cost reports referred by the Medicare contractors. Although our review identified 305 hospital cost reports submitted by the 9 selected Medicare contractors to CMS for reconciliation, CMS's records for the same Medicare contractors and time period listed only 269 cost reports.

FEDERAL REGULATIONS AND GUIDANCE

The regulations governing payments for operating costs under the IPPS are located in 42 CFR pt. 412. The specific regulations governing outlier payments are located at 42 CFR §§ 412.80 through 412.86.

Pursuant to 42 CFR § 412.84(i)(4), for discharges occurring on or after August 8, 2003, outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider (i.e., the hospital) and the CCR calculated at final settlement of the cost reporting period during which the discharge occurred. Additionally, if a hospital's total outlier payments during the period exceed \$500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during the period to make outlier payments, the Medicare contractor must suspend the settlement of the cost report and refer it to CMS for reconciliation (Claims Processing Manual, chapter 3, § 20.1.2.5). CMS was to perform these reconciliations (Claims Processing Manual, chapter 3, § 20.1.2.7, which was in effect during our audit period).

In addition, pursuant to 42 CFR § 412.84(m), which is effective for discharges occurring on or after August 8, 2003, outlier payments may be adjusted at the time of reconciliation to account for the time value of any underpayments or overpayments. Chapter 3, § 20.1.2.6, of the Claims Processing Manual that was in effect during our audit period provided guidance on how to apply the time value of money to the reconciled outlier dollar amount. Specifically, the Claims Processing Manual provision stated that the time value of money (that is, the interest accrued by

the outlier payment) stopped on the day that the CMS Central Office received notification of a cost report referral from a Medicare contractor.

RECONCILIATIONS NOT PERFORMED

Contrary to Federal regulations and guidance, CMS did not reconcile outlier payments associated with 292 of the 305 cost reports that were referred to it by the 9 selected Medicare contractors. As a result, the Medicare contractors did not reach final settlement of the 292 cost reports. For the 13 remaining cost reports, CMS evaluated information submitted by the Medicare contractors and correctly determined that reconciliations of outlier payments were not required.

The following table provides the number of cost report referrals, by FY, from Medicare contractors to CMS for reconciliation.¹⁵

Table: Cost Report Referrals by Medicare Contractors to CMS

CY	Reconciliation Not Required	2005	2006	2007	2008	2009	2010	Total
Number of referrals to CMS	13	3	37	96	65	47	44	305

CAUSES OF DELAYS IN RECONCILIATION PROCESS

As of the end of our fieldwork, CMS had not developed and implemented an automated system to recalculate outlier claims using actual CCRs without adversely affecting other data. And even if CMS had developed and implemented an automated system, it would not have performed all of the reconciliations because it did not maintain a complete list of cost reports referred by the Medicare contractors.

System Limitations

CMS did not complete reconciliations because of system limitations. In CMS Transmittal 2111, issued to Medicare contractors on December 3, 2010, CMS stated: "... due to system limitations, we were unable to reconcile any hospital outlier claims We also did not provide a process for Medicare contractors on how to reconcile outlier claims for those hospitals already flagged for outlier reconciliation ... or that could potentially be flagged for outlier reconciliation."

Discrepancy in Records of Cost Report Referrals

CMS did not maintain a complete list of cost reports referred by the Medicare contractors. Our evaluation of cost report data from the 9 selected Medicare contractors indicated that the Medicare contractors had referred 305 hospital cost reports to CMS for reconciliation of outlier

¹⁵ The timeframe covered by this table allows for the timelag between the end of a cost reporting period and the deadline for cost report settlement by the appropriate Medicare contractor. (See "Scope.")

payments. However, CMS's records for the same contractors and time period listed only 269 cost reports. Without a complete list, CMS could not ensure that all required reconciliations had been performed.

EFFECT OF FAILURE TO PERFORM RECONCILIATIONS

The 292 cost reports we identified had approximately \$664 million in associated unreconciled outlier payments. Because CMS did not reconcile the 292 cost reports, amounts that hospitals owe to Medicare for outlier overpayments and that Medicare owe to hospitals for outlier underpayments were unknown and outstanding at the conclusion of our fieldwork. After our fieldwork concluded, 1 Medicare contractor made preliminary estimates of overpayments associated with approximately \$37 million of the \$664 million in unreconciled outlier payments; these estimates involved 20 of the 292 cost reports we identified. As of July 15, 2011, this Medicare contractor estimated that hospitals will owe approximately \$22 million to Medicare when these 20 cost reports are brought to final settlement.

In addition to potentially overpaid and underpaid outlier payments, any adjustments that Medicare contractors identified during their cost report audits remain unresolved pending reconciliation and subsequent final settlement of cost reports. For the 292 cost reports we reviewed, the Medicare contractors' cost report audits determined that before outlier reconciliation, hospitals owed Medicare for overpayments associated with 236 cost reports. These overpayments, along with associated interest, represent funds that should have been returned to the Medicare Trust Fund. The cost report audits also determined that before outlier reconciliation, Medicare owed hospitals for underpayments associated with the remaining 56 cost reports. These underpayments, along with associated interest, had not been paid to the hospitals as of the end of our fieldwork.

RECOMMENDATIONS

We recommend that CMS:

- ensure that Medicare contractors reconcile outlier payments and perform final settlement on the 292 cost reports we reviewed in accordance with Federal regulations and guidance,
- ensure that Medicare contractors reconcile outlier payments and perform final settlement on all cost reports submitted after our audit period in accordance with Federal regulations and guidance,
- implement an automated system that will recalculate outlier claims to facilitate reconciliations, and
- work with the Medicare contractors to develop and maintain a complete and accurate list of the cost reports with outlier payments requiring reconciliation.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with all of our recommendations and described corrective actions that it had implemented or planned to implement.

CMS's comments appear in their entirety as the Appendix.

APPENDIX

APPENDIX: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

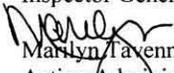
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAY 14 2012

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Washington, DC 20201

TO: Daniel R. Levinson
Inspector General

FROM: 
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance (A-07-10-02764)

Thank you for the opportunity to review and comment on the OIG Draft Report entitled, "The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance" (A-07-10-02764). The objective of this report is to determine whether the Centers for Medicare & Medicaid Services (CMS) reconciled outlier payments in accordance with Federal regulations and guidance. CMS appreciates OIG's effort to examine the outlier reconciliation policy.

CMS issued "Transmittal 2111/Change Request (CR) 7192" on December 1, 2010; this CR became effective on April 4, 2011. In that CR, CMS released the Lump Sum Utility to the Fiscal Intermediary Standard System (FISS) which is an automated utility that enables Medicare contractors to re-price claims offline for outlier reconciliation. Since April 4, 2011, CMS has approved over 200 cost reports referred to us by Medicare contractors for outlier payment reconciliation. CMS has also been working with the Medicare contractors and FISS to resolve any system issues with the Lump Sum Utility. CMS continues to monitor and track these outlier reconciliation requests by the Medicare contractors and providers. Additionally, once approval is granted, CMS remains committed to performing the outlier reconciliation as quickly as possible in order to return any overpayments to the Medicare trust fund.

OIG recommendations and the response to those recommendations are discussed below. CMS would like to thank OIG for the opportunity to review and comment on this report.

OIG Recommendation 1

OIG recommends that CMS ensure that Medicare contractors reconcile outlier payments and perform final settlement on the 292 cost reports we reviewed in accordance with Federal regulations and guidance.

CMS Response

CMS concurs with the recommendation. In Transmittal 2111/CR 7192, CMS provided instructions to FISS and Medicare contractors regarding the reconciliation process. CMS will monitor the final settlement process for these 292 cost reports and will require contractors to notify CMS when complete.

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OIG Recommendation 2

OIG recommends that CMS ensure that Medicare contractors reconcile outlier payments and perform final settlement on all cost reports submitted after our audit period in accordance with Federal regulations and guidance.

CMS Response

CMS concurs with the recommendation. In Transmittal 2111/CR 7192, CMS provided instructions to FISS and Medicare contractors regarding the reconciliation process. CMS will work with the contractors to ensure that all cost reports submitted after the OIG audit period have outlier reconciliations (where required) and cost reports are finally settled properly, in accordance with regulations and CMS manual provisions. CMS currently has instructions in the Desk Review and Audit Programs used by contractors to identify cost reports that require outlier reconciliation. CMS will review the documents to determine if clarification is needed. CMS also has contractor monitoring metrics established so CMS reviewers can ensure that the contractors are following the instructions, and complying with regulations and CMS manual provisions. Contractor monitoring will continue to ensure outlier reconciliations are handled properly.

OIG Recommendation 3

OIG recommends that CMS implement an automated system that will recalculate outlier claims to facilitate reconciliations.

CMS Response

CMS concurs with the recommendation. In Transmittal 2111/CR 7192, CMS provided instructions to FISS and Medicare contractors regarding use of the Lump Sum Utility to recalculate outlier claims to facilitate reconciliations. This utility is to be used by Medicare contractors to re-price outlier claims offline.

OIG Recommendation 4

The OIG recommends that CMS work with the Medicare contractors to develop and maintain a complete and accurate list of the cost reports with outlier payments requiring reconciliation.

CMS Response

CMS concurs with the recommendation. In Transmittal 2111/CR 7192, CMS required contractors to identify (“flag”) providers for outlier reconciliation and to submit lists of these providers to the Central Office for approval. The Center for Medicare maintains the lists of the hospitals submitted by the contractors for outlier reconciliation and lists of the hospitals for which outlier reconciliation is approved. Contractors’ processes for identifying providers eligible for reconciliation in accordance with policy are audited separately as discussed in responses to the first two recommendations.

CMS would like to thank OIG for the opportunity to review and comment on this report.