

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NATIONAL GOVERNMENT SERVICES,
INC., DID NOT ALWAYS REFER
MEDICARE COST REPORTS AND
RECONCILE OUTLIER PAYMENTS**

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EXECUTIVE SUMMARY

National Government Services, Inc., did not always refer cost reports whose outlier payments qualified for reconciliation to the Centers for Medicare & Medicaid Services. The financial impact of these unreferred cost reports was at least \$16.8 million that should be recouped from health care providers and returned to Medicare. In addition, National Government Services did not always reconcile the outlier payments associated with cost reports whose outlier payments qualified for reconciliation.

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) implemented inpatient outlier regulations in 2003 that authorized Medicare contractors to reconcile outlier payments before the settlement of certain hospital cost reports to ensure that these payments reflected the actual costs that each hospital had incurred. CMS policy stated that if a hospital's cost report met specified criteria for reconciliation, the Medicare contractor should refer it to CMS for reconciliation of outlier payments. Effective April 2011, CMS gave Medicare contractors the responsibility to perform reconciliations upon receipt of authorization from the CMS Central Office.

This review is one of a series of reviews to determine whether Medicare contractors had (1) referred the cost reports that qualified for reconciliation and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. One such contractor, National Government Services, Inc. (NGS), has been the Medicare contractor for Jurisdiction 6, which comprises Illinois, Minnesota, and Wisconsin, as well as for Jurisdiction 13, which comprises Connecticut and New York.

The objectives of this review were to determine whether NGS (1) referred cost reports to CMS for reconciliation in accordance with Federal guidelines and (2) reconciled the outlier payments associated with the referred cost reports by December 31, 2011.

BACKGROUND

CMS administers Medicare and uses a prospective payment system to pay Medicare-participating hospitals (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.

Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses due to unusually high-cost cases. Medicare contractors calculate outlier payments on the basis of claim submissions made by hospitals and by using hospital-specific cost-to-charge ratios (CCRs). Medicare contractors review cost reports that hospitals have submitted, make any necessary adjustments, and determine whether payment is owed to Medicare or to the hospitals. In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years after the date of the final settlement of that cost report. We refer to this as the 3-year reopening limit.

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether NGS had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.

WHAT WE FOUND

Of 80 cost reports with outlier payments that qualified for reconciliation, 23 cost reports had unreliable CCRs because their cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed; we discuss these 23 cost reports below. Of the 57 remaining cost reports with outlier payments that qualified for reconciliation, NGS referred 35 cost reports to CMS in accordance with Federal guidelines. However, NGS did not refer 22 cost reports that should have been referred to CMS for reconciliation.

Of the 22 cost reports that should have been referred to CMS for reconciliation but were not, 10 cost reports had not been settled. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with 8 of these 10 cost reports and (2) the recalculated outlier payments totaled at least \$19,689,662. We refer to this difference as "financial impact." We also calculated that \$2,921,656 was due from Medicare to the providers for the two other cost reports that should have been referred to CMS for reconciliation. The net financial impact of the outlier payments associated with these 10 unreferred cost reports was therefore at least \$16,768,006 that was due to Medicare. The 12 remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with those 12 cost reports totaled at least \$10,880,654 that may be due to Medicare (8 cost reports) and \$3,425,310 that may be due to the providers (4 cost reports). The net financial impact of the outlier payments associated with these 12 unreferred cost reports that had been settled and exceeded the 3-year reopening limit was therefore at least \$7,455,344 that was due to Medicare.

Of the 35 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, NGS had reconciled the outlier payments associated with 11 cost reports by December 31, 2011. However, NGS had not reconciled the outlier payments associated with the remaining 24 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 24 cost reports that were referred but not reconciled was at least \$102,498,576 that was due to Medicare (22 cost reports) and \$1,298,968 was due from Medicare to the providers (2 cost reports). The net financial impact of the outlier payments associated with these 24 cost reports that were referred but not reconciled was therefore at least \$101,199,608 that was due to Medicare.

Because we could not verify the original outlier payment calculation, we were unable to recalculate 1 of the 17,986 claims associated with the cost reports that we were recalculating and are setting aside \$9,778 in outlier payments associated with that claim for resolution by NGS and CMS.

Of the 23 cost reports that qualified for reconciliation and that had unreliable CCRs, NGS did not refer any cost reports that should have been referred to CMS for reconciliation. These 23 cost reports had not been settled and included 54,922 claims and \$94,215,459 in associated outlier payments. Because CMS had not resolved the issues related to the reconciliation of cost reports with unreliable CCRs, we were unable to calculate the financial impact for these cost reports and are setting aside the associated 54,922 claims and \$94,215,459 in outlier payments for resolution by NGS and CMS.

WHAT WE RECOMMEND

We recommend that NGS:

- review the 10 cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, and request CMS approval to:
 - recoup \$19,689,662 in funds and associated interest from health care providers (8 cost reports) and refund that amount to the Federal Government, and
 - return \$2,921,656 in funds and associated interest from Medicare to health care providers (2 cost reports);
- review the 12 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not, determine whether these cost reports may be reopened, and work with CMS to:
 - resolve \$10,880,654 in funds and associated interest from health care providers that may be due to the Federal Government (8 cost reports) and
 - resolve \$3,425,310 in funds and associated interest from Medicare that may be due to health care providers (4 cost reports);
- review the 24 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
 - reconcile the \$102,498,576 in associated outlier payments due to the Federal Government (22 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare, and
 - reconcile the \$1,298,968 in associated outlier payments due from Medicare to providers (2 cost reports), finalize these cost reports, and return the funds to the providers;
- work with CMS to resolve the \$9,778 in outlier payments associated with 1 claim that we could not recalculate;

- review the 23 cost reports with unreliable CCRs that should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports to CMS, and work with CMS to resolve the \$94,215,459 in outlier payments associated with these 23 cost reports that we could not recalculate;
- ensure that control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;
- ensure that policies and procedures are in place so that NGS reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, NGS concurred with our findings related to outlier status of the cost reports that (1) had not been settled and should have been referred to CMS for outlier reconciliation (our first recommendation) or (2) were properly referred to CMS and had outlier payments that qualified for reconciliation but were not reconciled (our third recommendation). However, NGS did not concur with our recommendation to recoup or pay the specific amounts associated with these cost reports. NGS stated that it would proceed with the outlier calculation and settlement of the cost reports, and the amounts recouped or paid would represent final settlement of the cost reports.

Regarding our second recommendation for cost reports that had been settled and had exceeded the 3-year reopening limit, NGS stated that it would not pursue these recoveries because the reopening timeframe had passed, and it would consult with CMS and seek direction on next steps in addressing these 12 cost reports.

NGS concurred with our fourth and fifth recommendations and agreed to work with CMS to resolve the issues related to the claim with outlier payments that we could not recalculate and cost reports with unreliable CCR ratios.

NGS concurred with our remaining three recommendations pertaining to its policies, procedures, and controls related to the outlier reconciliation process.

We maintain that all of our findings and recommendations are valid. Specific recoupment or payment amounts in our first and third recommendations are estimates. We will review the final settlement amounts that NGS provides after its outlier calculation and settlement of the cost reports. With respect to the 12 cost reports associated with our second recommendation, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of “similar fault.”

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INTRODUCTION

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) implemented inpatient outlier regulations in 2003 that authorized Medicare contractors to reconcile outlier payments before the settlement of certain hospital cost reports to ensure that these payments reflected the actual costs that each hospital had incurred. CMS policy stated that if a hospital's cost report met specified criteria for reconciliation, the Medicare contractor should refer it to CMS for reconciliation of outlier payments.¹ Effective April 2011, CMS gave Medicare contractors the responsibility to perform reconciliations upon receipt of authorization from the CMS Central Office.

In a previous Office of Inspector General (OIG) audit, we reported to CMS that 292 cost reports referred by 9 Medicare contractors for reconciliation had not been settled.² In that 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 follow up on that audit, we performed a series of reviews to determine whether the Medicare contractors had (1) referred the cost reports that qualified for reconciliation (a responsibility that already rested with the contractors) and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility.³ One such contractor, National Government Services, Inc. (NGS), has been the Medicare contractor for Jurisdiction 6, which comprises Illinois, Minnesota, and Wisconsin, as well as for Jurisdiction 13, which comprises Connecticut and New York.

OBJECTIVES

Our objectives were to determine whether NGS (1) referred cost reports to CMS for reconciliation in accordance with Federal guidelines and (2) reconciled the outlier payments associated with the referred cost reports by December 31, 2011.⁴

¹ Although CMS did not instruct Medicare contractors to refer hospitals in need of reconciliation until 2005, the instructions applied to cost reporting periods beginning on or after October 1, 2003. Moreover, CMS's instructions during this period changed the responsibility for performing reconciliations. CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003) instructed Medicare contractors to perform reconciliations. Later, Transmittal 707 (Change Request 3966; October 12, 2005) specified that CMS would perform reconciliations.

² *The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance* (A-07-10-02764), issued June 28, 2012.

³ Appendix A contains a list of related Office of Inspector General reports.

⁴ Although the CMS-established deadline for reconciling the cost reports was October 1, 2011, for this review we provided a 3-month grace period by establishing December 31, 2011, as our cutoff date.

BACKGROUND

Medicare and Outlier Payments

Under Title XVIII of the Social Security Act (the Act), Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS administers the program and uses a prospective payment system (PPS) to pay Medicare-participating hospitals (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.

Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses because of unusually high-cost cases (the Act, § 1886(d)(5)(A)). Medicare contractors calculate outlier payments on the basis of claim submissions made by hospitals and by using hospital-specific cost-to-charge ratios (CCRs).

Under CMS requirements that became effective in 2003, Medicare contractors were to refer hospitals' cost reports to CMS (cost report referral) for reconciliation of outlier payments (reconciliation) to correctly re-price submitted claims and settle cost reports. In December 2010, CMS stated that it had not performed reconciliations because of system limitations and directed the Medicare contractors to perform backlogged reconciliations (effective April 1, 2011), as well as all future reconciliations.

For this review, we focused on one of the 2003 requirements: to reconcile outlier payments before the final settlement of hospital cost reports to ensure that these payments are an accurate assessment of the actual costs incurred by each hospital.

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

To qualify for outlier payments, a claim must have costs that exceed a CMS-established cost threshold. Costs are calculated by multiplying covered charges by a hospital-specific 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 using the most current information available when processing a claim. 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)).⁵ More than one CCR can be used in a cost reporting period.

A Medicare contractor can, in limited circumstances, use a CCR other than the CCR from the most recent settled cost report or the most recent tentative settled cost report to calculate and pay claims (42 CFR § 412.84(i)(3)). This regulation specifies that a Medicare contractor may use a statewide average CCR if the contractor is unable to determine an accurate CCR for a hospital

⁵ These regulations effectively eliminated the use of the statewide average CCR for hospitals with a CCR that falls below the former CMS-established thresholds.

because of one of the following circumstances: a new hospital has not yet submitted its first Medicare cost report, a hospital's CCR is in excess of three standard deviations above the corresponding national geometric mean,⁶ or the Medicare contractor cannot obtain accurate data to calculate a CCR. Alternatively, the Medicare contractor can use a CMS-approved alternative CCR to calculate and pay claims if the contractor finds evidence that using data from the latest settled cost report would not result in the most accurate CCR (42 CFR § 412.84(i)(1)).⁷

A hospital must submit its cost reports, which can include outlier payments, to Medicare contractors within 5 months after the hospital's fiscal year ends. CMS instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report (*Provider Reimbursement Manual*, part 2, § 140). After accepting a cost report,⁸ 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 possible delays in the final settlement process.

After accepting a cost report—and regardless of whether it has brought that report to final settlement—the Medicare contractor forwards it to CMS, which maintains submitted cost reports in a database. We used this database in our analysis for this review.

The Medicare contractor reviews the cost report and may audit it before final settlement. If a cost report is audited, the Medicare contractor incorporates any necessary adjustments to identify reimbursable amounts and processes Medicare reimbursements due from or to the hospital.⁹ At the end of this process, the Medicare contractor issues the final settlement document, the Notice of Program Reimbursement (NPR), to the hospital. 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.

In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years¹⁰ after the date of the final settlement of that cost report (42 CFR § 405.1885(b)). We refer to this as the 3-year reopening limit.

⁶ These circumstances discussed in this Federal regulation are also cited in the *Medicare Claims Processing Manual* (Claims Processing Manual), chapter 3, section 20.1.2.2. The Claims Processing Manual further explains that the national geometric mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with 42 CFR § 412.8(b).

⁷ CMS may, on its own initiative, direct contractors to use an alternative CCR for the same reason (Claims Processing Manual, chap. 3, § 20.1.2.1(B)).

⁸ Medicare contractors do not accept every cost report on its initial submission. Medicare contractors can return cost reports to hospitals for correction, additional information, or other reasons.

⁹ Among other reasons, cost reports may be adjusted to reflect actual expenses incurred or to make allowances for recovery of expenses through sales or fees.

¹⁰ Cost reports may be reopened by Medicare contractors beyond 3 years for fraud or similar fault (42 CFR § 405.1885(b)(3); *Provider Reimbursement Manual*, part 1, § 2931.1 (F)).

Outlier payments may, under certain circumstances, be reconciled so that submitted claims can be correctly re-priced before final settlement of a cost report. For this review, we considered the outlier payments associated with a cost report to have been reconciled and the reconciliation process to have been completed if all claims had been correctly re-priced and the cost report itself had been brought to final settlement.

CMS Changes in the Hospital Outlier Payment Reconciliation Methodology

Outlier Payment Reconciliation

CMS developed new outlier regulations¹¹ and guidance in 2003 after reporting that, from Federal fiscal years 1998 through 2002, it paid approximately \$9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.^{12, 13} The 2003 regulations were intended to ensure that outlier payments were limited to extraordinarily high-cost cases and that final outlier payments reflected an accurate assessment of the actual costs the hospital had incurred. Medicare contractors were to refer hospitals' cost reports to CMS for reconciliation so CMS could correctly re-price submitted claims and allow Medicare contractors to settle cost reports.¹⁴

Reconciliation Process

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. The actual CCR may be different from the CCR from the most recently settled or most recent tentative settled cost report that was used to calculate individual outlier claim payments during the cost reporting period. If a hospital's total outlier payments during the cost reporting period exceed \$500,000 and the actual CCR¹⁵ is found to be plus or minus 10 percentage points of the CCR used during that period to calculate outlier payments, CMS policy requires the Medicare contractor to refer the hospital's cost report to CMS for reconciliation (Claims Processing Manual, chapter 3, § 20.1.2.5). For this report, we refer to the process of determining whether a cost report qualifies for referral as the "reconciliation test."

¹¹ 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*, 68 Fed. Reg. 34494 (June 9, 2003).

¹² CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003).

¹³ CMS had projected that it would pay approximately \$17.6 billion for Medicare IPPS outlier payments but actually made approximately \$26.6 billion in payments.

¹⁴ Although CMS did not instruct Medicare contractors to refer hospital cost reports in need of reconciliation until 2005, the 2003 regulations were applicable to cost reporting periods beginning on or after October 1, 2003.

¹⁵ Under the provisions of 42 CFR § 412.84(i)(4) and according to our discussions with CMS officials, statewide average or alternative CCRs should not be used in place of the actual CCRs calculated from cost report data.

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.

CMS Transmittal 707¹⁶ 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, 2011. In CMS Transmittal 2111,¹⁷ CMS directs the Medicare contractors to assume the responsibility to perform the reconciliations effective April 1, 2011. CMS Transmittal 2111 also says that contractors should perform reconciliations only if they receive prior approval from CMS. In that document, CMS states that it had not performed reconciliations because of system limitations.

To process the backlog of cost reports requiring reconciliation, CMS instructed Medicare contractors to submit to CMS, between April 1 and April 25, 2011, a list of hospitals whose cost reports had been flagged for reconciliation¹⁸ 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.

CMS Lump Sum Utility Used in Outlier Recalculation

Specialized software helps Medicare contractors perform reconciliations and process cost reports. Medicare contractors use the Fiscal Intermediary Standard System (FISS) Lump Sum Utility for reconciliations. The FISS Lump Sum Utility calculates the difference between the original and revised PPS payment amounts and generates a report to CMS. Delays in software updates to the FISS Lump Sum Utility can prevent Medicare contractors from recalculating the outlier payments.

Cost Reports on Hold

In August 2008, CMS instructed Medicare contractors to hold for settlement, rather than settle, any cost reports affected by revised Supplemental Security Income (SSI) ratios. In addition, CMS instructed Medicare contractors to stop issuing final settlements on cost reports using the fiscal years 2006 and 2007 SSI ratios in the calculation of disproportionate share hospital (DSH) payments. CMS subsequently expanded the “DSH/SSI hold” to include cost reports using the fiscal years 2008 and 2009 SSI ratios. The DSH/SSI hold remained in effect until CMS published the updated SSI ratios in June 2012.

¹⁶ CMS, “IPPS Outlier Reconciliation,” Claims Processing Manual, Pub. No. 100-04, Transmittal 707 (Change Request 3966; October 12, 2005).

¹⁷ 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*, Claims Processing Manual, Transmittal 2111 (Change Request 7192; December 3, 2010).

¹⁸ CMS uses the term “flagged” to refer to outlier payments whose reconciliations were backlogged between 2005 and April 1, 2011.

HOW WE CONDUCTED THIS REVIEW

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether NGS had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011. If the cost reports had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and, where necessary, used CMS's database to calculate the amounts due to Medicare or to providers.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains details of our audit scope and methodology.

FINDINGS

Of 80 cost reports with outlier payments that qualified for reconciliation, 23 cost reports had unreliable CCRs because their cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed; we discuss these 23 cost reports below. Of the 57 remaining cost reports with outlier payments that qualified for reconciliation, NGS referred 35 cost reports to CMS in accordance with Federal guidelines. However, NGS did not refer 22 cost reports that should have been referred to CMS for reconciliation.

Of the 22 cost reports that should have been referred to CMS for reconciliation but were not, 10 cost reports had not been settled. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with 8 of these 10 cost reports and (2) the recalculated outlier payments totaled at least \$19,689,662. We refer to this difference as "financial impact."¹⁹ We also calculated that \$2,921,656 was due from Medicare to the providers for the two other cost reports that should have been referred to CMS for reconciliation. The net financial impact of the outlier payments associated with these 10 unreferred cost reports was therefore at least \$16,768,006 that was due to Medicare. The 12 remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with those 12 cost reports totaled at least \$10,880,654 that may be due to Medicare (8 cost reports) and \$3,425,310 that may be due to the providers (4 cost reports). The net financial impact of the outlier payments associated with these 12 unreferred cost reports that had been settled and exceeded the 3-year reopening limit was therefore at least \$7,455,344 that was due to Medicare.

¹⁹ The financial impacts that we convey in this report take the time value of money into account and thus also include any accrued interest; see also Appendix B.

Of the 35 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, NGS had reconciled the outlier payments associated with 11 cost reports by December 31, 2011. However, NGS had not reconciled the outlier payments associated with the remaining 24 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 24 cost reports that were referred but not reconciled was at least \$102,498,576 that was due to Medicare (22 cost reports) and \$1,298,968 was due from Medicare to the providers (2 cost reports). The net financial impact of the outlier payments associated with these 24 cost reports that were referred but not reconciled was therefore at least \$101,199,608 that was due to Medicare.

Because we could not verify the original outlier payment calculation, we were unable to recalculate 1 of the 17,986 claims associated with the cost reports that we were recalculating and are setting aside \$9,778 in outlier payments associated with that claim for resolution by NGS and CMS.²⁰

Of the 23 cost reports that qualified for reconciliation and that had unreliable CCRs, NGS did not refer any cost reports that should have been referred to CMS for reconciliation.²¹ These 23 cost reports had not been settled and included 54,922 claims and \$94,215,459 in associated outlier payments. Because CMS had not resolved the issues related to the reconciliation of cost reports with unreliable CCRs, we were unable to calculate the financial impact for these cost reports and are setting aside the associated 54,922 claims and \$94,215,459 in outlier payments for resolution by NGS and CMS.

See Appendix C for a summary of the status of the 57 cost reports with respect to referral and reconciliation, as well as the associated dollar amounts due to Medicare or to providers. See Appendix D for a summary of the status of the 23 cost reports with unreliable CCRs with respect to referral and reconciliation, as well as information on the number of claims and the associated outlier payments that we are setting aside.

FEDERAL REQUIREMENTS

Federal regulations state that for discharges occurring on or after October 1, 2003, the CCR applied at the time a claim is processed (and outlier payments are made) 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)).

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 calculate outlier payments, CMS policy requires the Medicare contractor to refer the hospital's cost report to CMS for reconciliation (Claims Processing Manual, chapter 3, § 20.1.2.5).

²⁰ This amount is separate from the financial impact amounts mentioned in the two immediately preceding paragraphs.

²¹ These cost reports qualified for reconciliation using CCRs that were unreliable. Later in this report, we set aside the outlier claims in those reports and the associated payments for resolution by NGS and CMS.

CMS 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, 2011. In CMS Transmittal 2111, CMS directs the Medicare contractors to assume the responsibility to perform the reconciliations effective April 1, 2011, although the CMS Central Office would determine whether reconciliations would be performed. In this document, CMS also states that it had not performed reconciliations because of system limitations.

Our calculations of the financial impact of the findings developed in this audit took into account the time value of money. Federal regulations for discharges occurring on or after August 8, 2003, state that outlier payments may be adjusted at the time of reconciliation to account for the time value of any underpayments or overpayments (42 CFR § 412.84(m)). The provisions of the Claims Processing Manual that were in effect during our audit period provided guidance on how to apply the time value of money to the reconciled outlier dollar amount. Specifically, these provisions state that the time value of money stops accruing on the day that the CMS Central Office receives notification of a cost report referral from a Medicare contractor (Claims Processing Manual, chapter 3, § 20.1.2.6).

COST REPORTS NOT REFERRED

Of the 80 cost reports with outlier payments that qualified for reconciliation, 23 cost reports had unreliable CCRs and are discussed further below. Of the 57 remaining cost reports with outlier payments that qualified for reconciliation, NGS referred 35 cost reports to CMS in accordance with Federal guidelines. However, NGS did not refer 22 cost reports that should have been referred to CMS for reconciliation.²²

Cost Reports Within the 3-Year Reopening Limit

Of the 22 cost reports that NGS did not refer to CMS for reconciliation, 10 cost reports had not been settled and should have been referred to CMS for reconciliation. Because NGS had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified and referred to CMS, it did not perform the reconciliation test to identify and refer these cost reports.²³ We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these unrefereed cost reports totaled at least \$19,689,662 that was due to Medicare (eight cost reports) and \$2,921,656 that was due to the providers (two cost reports).

²² We are not including one additional cost report submitted by a provider who transitioned to another Medicare contractor and left the Medicare program during our audit period. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with this cost report was at least \$97,568 that was due to Medicare. We are separately providing detailed data on this cost report for resolution by CMS.

²³ Four of these cost reports were also on hold because of the SSI-related issue discussed in “Background.”

Cost Reports Outside the 3-Year Reopening Limit

Of the 22 cost reports that NGS did not refer to CMS for reconciliation, the remaining 12 cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. NGS did not refer the 12 cost reports to CMS because NGS had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified; were referred to CMS; and, if necessary, were reopened before the 3-year reopening limit. As a result of the inadequacy of these control procedures:

- NGS did not perform the reconciliation test to identify and refer nine cost reports that qualified for reconciliation and
- NGS did not correctly perform the reconciliation test for three cost reports and incorrectly concluded that these cost reports did not meet the criteria for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these 12 cost reports totaled at least \$10,880,654 that may be due to Medicare (8 cost reports) and \$3,425,310 that may be due to the providers (4 cost reports).

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 35 referred cost reports whose outlier payments qualified for reconciliation, NGS reconciled the outlier payments associated with 11 cost reports by December 31, 2011. However, NGS did not reconcile the outlier payments associated with 24 cost reports by December 31, 2011. The status of each of the cost reports with unreconciled outlier payments was as follows:

- 19 cost reports received CMS approval and were undergoing the reconciliation process;
- 5 cost reports were on hold because CMS had not calculated revised SSI ratios.

For the 19 cost reports that had received CMS approval and were undergoing the reconciliation process, NGS's policies and procedures did not ensure that it reconciled all outlier payments associated with these referred cost reports that qualified for reconciliation in accordance with Federal guidelines. For the other five cost reports that were referred but whose outlier payments had not been reconciled, CMS bore principal responsibility for the delays that we have described above.²⁴

We calculated that for the 24 referred cost reports whose outlier payments NGS did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least \$102,498,576 that was due to Medicare (22 cost reports) and \$1,298,968 that was due to the providers (2 cost reports).

²⁴ We will report separately to CMS on issues related to cost report referral and outlier payment reconciliation in a future review.

CLAIM THAT COULD NOT BE RECALCULATED

The 24 referred cost reports with unreconciled outlier payments included 1 claim with \$9,778 in associated outlier payments. We were unable to recalculate this claim because we could not verify the original outlier payment calculation. We are therefore setting aside the \$9,778 for resolution by NGS and CMS. We are separately providing detailed data on the claim that we could not recalculate to NGS.

COST REPORTS WITH UNRELIABLE COST-TO-CHARGE RATIOS

The Claims Processing Manual requires Medicare contractors to use specific lines from the cost report data to calculate the actual CCRs that are, in turn, used to determine whether a cost report qualifies for reconciliation (chapter 3, § 20.1.2.1).²⁵ Some hospitals, though, do not use a formal charge structure and may, instead, bill a flat fee for services or decide not to charge certain beneficiaries at all. For this reason, the actual CCRs that Medicare contractors computed using such hospitals' cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed. In addition, for some cost reports (and during several cost reporting periods), the actual CCRs computed using cost report data were significantly and consistently higher than the CCRs that were used to pay claims. Although Medicare contractors may use statewide average and CMS-approved alternative CCRs to pay claims during the cost reporting period in situations when the cost report's actual CCRs may be unreliable, CMS instructions require that the actual CCR be used to determine whether a cost report qualifies for reconciliation. We identified 23 cost reports as having unreliable CCRs.

Of the 23 cost reports that qualified for reconciliation and that had unreliable CCRs, NGS did not refer any cost reports that should have been referred to CMS for reconciliation.²⁶ None of these cost reports had been settled. Because NGS had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified and referred to CMS, NGS did not perform the reconciliation test to identify and refer these 23 cost reports.

Because CMS had not resolved the issues related to the reconciliation of cost reports with unreliable CCRs (it had not, for example, provided instructions on recalculating the outlier payments associated with cost reports that did not use a formal charge structure or whose outlier payments were paid using statewide average or CMS-approved alternative CCRs), we were unable to calculate the financial impact for these cost reports and are setting aside the 54,922 claims and \$94,215,459 in associated outlier payments for resolution by NGS and CMS.

²⁵ As stated in "Background," 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 using the most current information available when processing a claim.

²⁶ Eleven of these cost reports were also on hold because of the SSI-related issue discussed in "Background."

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with the 10 unreferrred cost reports that were within the 3-year reopening limit was at least \$19,689,662 that was due to Medicare (8 cost reports) and \$2,921,656 that was due to the providers (2 cost reports). Therefore, the net financial impact to Medicare of the 10 unreferrred cost reports was at least \$16,768,006. These cost reports should have been referred to CMS for reconciliation but were not and were also not reconciled even though their outlier payments qualified for reconciliation.

Also as of December 31, 2011, the financial impact of the outlier payments associated with the 12 cost reports that exceeded the 3-year reopening limit and that should have been referred to CMS for reconciliation but were not was at least \$10,880,654 that may be due to Medicare (8 cost reports) and \$3,425,310 that may be due to the providers (4 cost reports). Therefore, the net financial impact to Medicare of the 12 unreferrred cost reports that had been settled and exceeded the 3-year reopening limit was at least \$7,455,344.

For the 24 referred cost reports whose outlier payments NGS did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least \$102,498,576 that was due to Medicare (22 cost reports) and \$1,298,968 that was due to the providers (2 cost reports). Therefore, the net financial impact to Medicare of the 24 cost reports with unreconciled outlier payments was at least \$101,199,608.

The financial impact summarized here does not take into account the amounts that we are setting aside for resolution by NGS and CMS (that is, the amounts associated with the 1 claim that we were unable to recalculate and the amounts associated with the 23 cost reports with unreliable CCRs).

RECOMMENDATIONS

We recommend that NGS:

- review the 10 cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, and request CMS approval to:
 - recoup \$19,689,662 in funds and associated interest from health care providers (8 cost reports) and refund that amount to the Federal Government, and
 - return \$2,921,656 in funds and associated interest from Medicare to health care providers (2 cost reports);
- review the 12 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not, determine whether these cost reports may be reopened, and work with CMS to:

- resolve \$10,880,654 in funds and associated interest from health care providers that may be due to the Federal Government (8 cost reports) and
- resolve \$3,425,310 in funds and associated interest from Medicare that may be due to health care providers (4 cost reports);
- review the 24 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
 - reconcile the \$102,498,576 in associated outlier payments due to the Federal Government (22 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare, and
 - reconcile the \$1,298,968 in associated outlier payments due from Medicare to providers (2 cost reports), finalize these cost reports, and return the funds to the providers;
- work with CMS to resolve the \$9,778 in outlier payments associated with 1 claim that we could not recalculate;
- review the 23 cost reports with unreliable CCRs that should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports to CMS, and work with CMS to resolve the \$94,215,459 in outlier payments associated with these 23 cost reports that we could not recalculate;
- ensure that control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;
- ensure that policies and procedures are in place so that NGS reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

AUDITEE COMMENTS

In written comments on our draft report, NGS concurred with our findings related to outlier status of the cost reports that (1) had not been settled and should have been referred to CMS for outlier reconciliation (our first recommendation) or (2) were properly referred to CMS and had outlier payments that qualified for reconciliation but were not reconciled (our third recommendation). However, NGS did not concur with our recommendation to recoup or pay the specific amounts associated with these cost reports. NGS stated that it would proceed with the outlier calculation and settlement of the cost reports, and the amounts recouped or paid would

represent final settlements of these cost reports. NGS specified that it had already completed the outlier reconciliation calculations for 9 of the 24 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation.

Regarding our second recommendation for cost reports that had been settled and had exceeded the 3-year reopening limit, NGS agreed that the 12 cost reports should have been referred to CMS for outlier reconciliation. NGS stated that it would not pursue these recoveries because the reopening timeframe had passed and it would consult with CMS and seek direction on the next steps in addressing these 12 cost reports.

NGS concurred with our fourth and fifth recommendations and agreed to work with CMS to resolve the issues related to the claim with outlier payments that we could not recalculate and cost reports with unreliable CCR ratios.

NGS concurred with our remaining three recommendations pertaining to its policies, procedures, and controls related to the outlier reconciliation process. For our final recommendation, NGS stated that it would respond with an analysis of cost reports with year ends subsequent to December 31, 2008, and would address any outlier issues according to Federal guidelines.

NGS's comments appear in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that all of our findings and recommendations are valid.

Specific recoupment or payment amounts in our first and third recommendations are estimates. We will review the final settlement amounts that NGS provides after its outlier calculation and settlement of the cost reports.

With respect to the 12 cost reports associated with our second recommendation, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "similar fault." Specifically, 42 CFR § 405.1885(b)(3) provides that a Medicare payment contractor (e.g., NGS) may reopen an initial determination *at any time* if the determination was procured by fraud or similar fault. For example, a Medicare payment contractor may reopen a cost report after finding that a provider received money that it knew or reasonably should have known it was not entitled to retain (73 Fed. Reg. 30190, 30233 (May 23, 2008)). Because the outlier reconciliation rules are promulgated in Federal regulations, as noted in this report, providers knew or should have known the rules when their cost reports were settled. We believe that these regulations constitute a sufficient basis for our second recommendation and recognize that ultimately CMS, as the cognizant Federal agency, has the authority to decide how to resolve the recommendations in this audit report. Accordingly, we continue to recommend that NGS determine whether the providers associated with the 12 unreferral cost reports procured Medicare funds by "similar fault" and work with CMS to resolve their \$7,455,344 (\$10,880,654 - 3,425,310) in outlier payments.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 1</i>	A-07-13-02795	07/22/15
<i>CGS Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-13-02791	05/29/15
<i>Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 11</i>	A-07-10-02775	04/23/15
<i>National Heritage Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00024	04/21/15
<i>Cahaba Government Benefit Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00019	03/30/15
<i>First Coast Service Options, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00022	03/27/15
<i>Novitas Solutions, Inc. (Formerly Highmark Medicare Services, Inc.), Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00023	03/27/15
<i>National Government Services, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 8</i>	A-05-14-00046	03/16/15
<i>Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02774	12/16/14
<i>Wisconsin Physicians Service Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02777	11/18/14
<i>Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-11-02773	10/29/14

<i>Trailblazer Health Enterprises Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required</i>	A-07-10-02776	06/10/14
<i>The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance</i>	A-07-10-02764	06/28/12

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether NGS had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.²⁷ If the cost reports had not been reconciled by December 31, 2011, we determined the status of each of the cost reports as of that date and calculated the amounts due to Medicare or to providers.

We performed audit work in our Chicago, Illinois, regional office from November 2010 to December 2014.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to NGS and other Medicare contractors concerning the reconciliation process and the Medicare contractors' responsibilities, including those related to the reconciliation of cost reports with unreliable CCRs;
- obtained from CMS a list of cost reports that Medicare contractors had referred for reconciliation;
- held discussions with NGS officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed NGS's policies and procedures regarding referral to CMS and reconciliation of cost reports;
- reviewed provider lists from all Medicare contractors to determine which providers were under NGS's jurisdiction as of November 4, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that NGS had referred to CMS for reconciliation during our audit period;

²⁷ Although the CMS-established deadline for reconciling the cost reports was October 1, 2011, for this review we provided a 3-month grace period by establishing December 31, 2011, as our cutoff date.

- obtained cost report data from CMS’s database for cost reports with fiscal-year ends during our audit period;
- obtained the inpatient acute care and long-term care hospital provider-specific files (PSFs) from the CMS Web site;
- determined which cost reports qualified for reconciliation by:
 - using the information in a CMS database to identify acute-care and long-term-care cost reports that had greater than \$500,000 in outlier payments²⁸ and
 - using the information in CMS’s database and PSF data to calculate and compare the actual and weighted average CCRs to determine whether the resulting variance was greater than 10 percentage points;
- verified that NGS used the three different types of outlier payments specified by Federal regulations²⁹ (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;
- requested that NGS provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;³⁰
- reviewed NGS’s response and categorized the cost reports according to their respective statuses;
- verified whether NGS had referred the cost reports before the date of the audit notification letter;
- verified that all of the cost reports we reviewed met the criteria for reconciliation;
- performed the following actions for cost reports that qualified for outlier reconciliation but for which NGS did not recalculate the outlier payments:
 - obtained the detailed Provider Statistical & Reimbursement reports from NGS or obtained the National Claims History data from CMS;
 - verified the original outlier payments using the CCR that was used to pay the claim;³¹

²⁸ CMS cost report data included operating and capital payments but did not include short-stay outlier payments.

²⁹ Claims Processing Manual, chapter 3, § 20.1.2.5.

³⁰ Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by NGS.

³¹ We set aside claims whose original outlier payments we could not verify.

- recalculated the outlier payment amounts for those cost reports that NGS did not recalculate using the actual CCRs;
 - identified the claim that we were unable to recalculate because we could not verify the original outlier payment calculation; and
 - calculated accrued interest³² as of the date that the cost report was referred to CMS (for unreferred cost reports or those that were referred after December 31, 2011, we calculated the amount of accrued interest as of December 31, 2011);
- summarized the results of our analysis, including the total amount due to or from Medicare; and
 - provided the results of our review to NGS officials on December 17, 2014.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

³² We calculated interest by referring to the Claims Processing Manual, chapter 3, § 20.1.2.6.

**APPENDIX C: SUMMARY OF AMOUNTS DUE TO MEDICARE OR PROVIDERS
BY COST REPORT CATEGORY**

Table 1: Total Cost Reports and Amounts Due

Grand Total	Due to Medicare	Due to Provider
80 cost reports	\$160,428,397	\$13,207,862

Table 2: Cost Reports Not Referred (OIG Identified)

Cost Report Category	Reconciled	Not Reconciled			Not Reconciled Subtotal	Total
		Within 3 Years		Past 3 Years		
		In Process	On Hold			
Number of cost reports	0	6	4	12	22	22
Balance due to Medicare	\$0	\$9,127,065	\$6,705,192	\$8,510,780	\$24,343,037	\$24,343,037
Interest due to Medicare	0	1,986,610	1,870,795	2,369,874	6,227,279	6,227,279
Balance due to provider	0	2,284,656	0	2,615,259	4,899,915	4,899,915
Interest due to provider	0	637,000	0	810,051	1,447,051	1,447,051
Total due to Medicare	\$0	\$11,113,675	\$8,575,987	\$10,880,654	\$30,570,316	\$30,570,316
Total due to provider	\$0	\$2,921,656	\$0	\$3,425,310	\$6,346,966	\$6,346,966

Table 3: Cost Reports Referred (Medicare Contractor Identified)

Cost Report Category	Reconciled	Not Reconciled			Not Reconciled Subtotal	Total
		Within 3 Years		Past 3 Years		
		In Process	On Hold			
Number of cost reports	11	19	5	0	24	35
Balance due to Medicare	\$22,756,755	\$65,816,171	\$23,319,262	\$0	\$89,135,433	\$111,892,188
Interest due to Medicare	4,602,750	9,305,641	4,057,502	0	13,363,143	17,965,893
Balance due to provider	4,934,973	1,145,449	0	0	1,145,449	6,080,422
Interest due to provider	626,955	153,519	0	0	153,519	780,474
Total due to Medicare	\$27,359,505	\$75,121,812	\$27,376,764	\$0	\$102,498,576	\$129,858,081
Total due to provider	\$5,561,928	\$1,298,968	\$0	\$0	\$1,298,968	\$6,860,896

Note: The dollar amounts associated with these cost reports do not reflect one claim that we were unable to recalculate.

**APPENDIX D: SUMMARY OF AMOUNTS BEING SET ASIDE
FOR COST REPORTS WITH UNRELIABLE COST-TO-CHARGE RATIOS
BY COST REPORT CATEGORY**

**Table 4: Cost Reports With Unreliable Cost-to-Charge Ratios That Were Not Referred
(OIG Identified)**

Cost Report Category	Reconciled	Not Reconciled			Total
		Within 3 Years		Past 3 Years	
		In Process	On Hold		
Number of cost reports	0	12	11	0	23
Number of claims being set aside	0	23,748	31,174	0	54,922
Outlier payments being set aside	\$0	\$29,539,023	\$64,676,436	\$0	\$94,215,459

APPENDIX E: AUDITEE COMMENTS



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June 16, 2015

Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

Report Number: A-05-11-00016

Dear Ms. Fulcher:

National Government Services (NGS) has reviewed the Office of Inspector General (OIG) draft report entitled National Government Services, Inc. Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments. Noted below are NGS' comments on the recommendations proposed by the OIG. The OIG report refers to 80 cost reports and includes three specific recommendations based on the status of outlier referrals and/or settlement of each cost report. The OIG has two recommendations related to unusual circumstances in which NGS is requested to work with CMS toward a resolution. Three additional recommendations pertaining to NGS policies, procedures and process controls relating to the outlier reconciliation process are also noted.

The OIG's first recommendation relates to ten cost reports that had not been settled and should have been referred to CMS for reconciliation. NGS concurs with the OIG finding relative to outlier status on these ten cost reports. NGS has referred all but one of these cost reports to CMS seeking approval to proceed with the outlier reconciliation. The OIG report goes on to recommend recoupment of estimated outlier overpayments and payment of estimated outlier amounts due to providers. NGS disagrees with the OIG recommendation to recoup/pay the specific amounts noted in the report. Rather, after these cost reports are returned by CMS with an approval to complete the outlier reconciliation, NGS will proceed with the outlier calculation and settlement of the cost report. In each case, the amount recouped or paid will represent final settlement of the cost report. NGS will isolate the impact of the outlier reconciliation plus interest and report the results to the OIG subsequent to cost report settlement.

The OIG's second recommendation relates to twelve cost reports that have been settled. In each case, the settlement now exceeds the 3-year window for reopening a cost report. These twelve cost reports should have been referred to CMS for outlier reconciliation prior to settlement, but they were not referred. The OIG also identifies an expected amount to be recovered or paid pursuant to reopening and completion of the outlier reconciliation. NGS understands that it is precluded from reopening a cost report more than three years after the issuance of a Notice of Program Reimbursement (final settlement). NGS will not pursue these twelve recoveries/payments since the reopening timeframe has passed. NGS will consult with CMS and seek direction on any next steps in addressing these twelve cost reports.

The OIG's third recommendation relates to 24 cost reports that were properly referred by NGS to CMS and that had outlier payments that qualified each for reconciliation. The OIG goes on to estimate the

MEDICARE



funds to be recouped or paid to these providers pursuant to completion of the outlier reconciliation. NGS disagrees with the OIG recommendation to recoup or pay the specific amounts noted in the report. Rather, since each of these referrals has been approved by CMS, NGS will proceed with the outlier reconciliation and settlement of the cost report as long as no other 'settlement hold' is applicable. Of the 24 cost reports, NGS has completed nine of the outlier reconciliation calculations. For these nine cost reports, the determination of the outlier reconciliation impact and related interest can be specifically identified. NGS will proceed with completion of the outlier reconciliations for the other 15 cost reports using the FISS Lump Sum Utility program. In each case, the amount recouped or paid will represent final settlement of the cost report. NGS will isolate the impact of the outlier reconciliation plus interest and report the results to the OIG subsequent to final settlement of the cost report.

The OIG has identified two unusual circumstances for which the recommendation is for NGS to work with CMS to resolve. The OIG has identified a claim with outlier payments that it could not recalculate. The OIG also identified 23 cost reports with unreliable cost to charge ratios that prevented the OIG from recalculating the outlier payment. NGS concurs with the OIG recommendations and agrees to work with CMS to resolve these unusual issues.

The OIG makes three additional recommendations; NGS concurs with each one. First, the OIG recommends control procedures be in place and effective for identifying, referring, and reopening cost reports to which outlier reconciliation applies. NGS has tightened its processes related to the calculation, determination and referral of cost reports related to outlier reconciliation. NGS is confident that our current procedures respond to this OIG recommendation. Second, the OIG recommends that policies and procedures be in place so that reconciliation of outlier payments is in accordance with Federal guidelines. NGS is confident that our current procedures respond to this OIG recommendation. Finally, the OIG recommends that all cost reports submitted since the end of the OIG audit period be reviewed for outlier reconciliation and referred to CMS as appropriate. Although NGS is confident that the processes currently in place for reviewing outlier status have captured the appropriate determination, NGS will respond to this recommendation with an analysis of cost reports with year ends subsequent to 12/31/08 and will address any outlier issues according to Federal guidelines.

NGS appreciates the opportunity to respond to the OIG report. We look forward to issuance of the final report.

Sincerely,



Eugene Nickerson
Director, Audit and Reimbursement, JK
National Government Services



John Stoll
Manager, Audit and Reimbursement, J6
National Government services