

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CAHABA GOVERNMENT BENEFIT
ADMINISTRATORS, LLC,
DID NOT ALWAYS REFER
MEDICARE COST REPORTS AND
RECONCILE OUTLIER PAYMENTS**

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**March 2015
A-05-11-00019**

Office of Inspector General

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EXECUTIVE SUMMARY

Cahaba Government Benefit Administrators, LLC, 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 \$8.5 million that should be recouped from health care providers and returned to Medicare. In addition, Cahaba 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, Cahaba Government Benefit Administrators, LLC (Cahaba), had been since 2009 the Medicare contractor for Jurisdiction 10, which comprises Alabama, Georgia, and Tennessee.

The objectives of this review were to determine whether Cahaba (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. Medicare contractors review cost reports that hospitals have submitted, make any necessary adjustments, and determine whether payment is owed to Medicare or to the hospital. 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 Cahaba 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 13 cost reports with outlier payments that qualified for reconciliation, Cahaba referred 5 cost reports to CMS in accordance with Federal guidelines. However, Cahaba did not refer eight cost reports that should have been referred to CMS for reconciliation. Of these eight, Cahaba had referred and reconciled the outlier payments associated with one cost report after we started our audit. The remaining seven cost reports had not been settled and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between the outlier payments associated with the seven cost reports and the recalculated outlier payments totaled at least \$8,488,306. We refer to this difference as "financial impact."

Of the five cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Cahaba had reconciled the outlier payments associated with three cost reports by December 31, 2011. However, Cahaba had not reconciled the outlier payments associated with the remaining two cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with one of the two cost reports that were referred but not reconciled was \$601,785 that was due to Medicare. The remaining cost report had been settled and had exceeded the 3-year reopening limit. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with this cost report was at least \$532,970 that may be due to Medicare.

Because we could not verify the original outlier payment calculation, we were unable to recalculate 1 of the 477 claims associated with the cost reports that we were recalculating and are setting aside \$113,613 in outlier payments associated with that claim for resolution by Cahaba and CMS.

WHAT WE RECOMMEND

We recommend that Cahaba:

- review the seven 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, request CMS approval to recoup at least \$8,488,306 in funds and associated interest from health care providers, and refund that amount to the Federal Government;
- review one cost report that was referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$601,785 in associated outlier payments due to the Federal Government, finalize this cost report, and ensure that the provider returns the funds to Medicare;

- review one cost report that had been referred to CMS, had been settled, had exceeded the 3-year reopening limit, and had outlier payments that qualified for reconciliation; determine whether this cost report may be reopened, and work with CMS to resolve at least \$532,970 in funds and associated interest from the health care provider that may be due to the Federal Government;
- work with CMS to resolve the \$113,613 in outlier payments associated with one claim that we could not recalculate;
- ensure 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 policies and procedures are in place so that it 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, Cahaba generally concurred with all of our recommendations and described corrective actions that it had taken or planned to take.

Regarding the cost report that had exceeded the 3-year reopening limit, Cahaba stated that this cost report was incorrectly settled by a prior Medicare contractor. Cahaba was unable to initiate a cost reopening because the 3-year reopening limit had elapsed. As a result, CMS disapproved Cahaba's request to reconcile outlier payments.

After reviewing Cahaba's comments, we maintain that all of our findings and recommendations are valid. Regarding the cost report that had exceeded the 3-year reopening limit, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "fraud or 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, Cahaba Government Benefit Administrators, LLC (Cahaba), had been since 2009 the Medicare contractor for Jurisdiction 10, which comprises Alabama, Georgia, and Tennessee.

OBJECTIVES

Our objectives were to determine whether Cahaba (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 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 (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 due to 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 reprice 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)). More than one CCR can be used in a cost reporting period.

A hospital must submit its cost reports, which can include outlier payments, to Medicare contractors within 5 months after the hospital's fiscal year (FY) 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,⁵ 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 finalize Medicare reimbursements due from or to hospitals.⁶ 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 years⁷ 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.

Outlier payments may under certain circumstances be reconciled so that submitted claims can be correctly repriced 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 complete if all claims had been correctly repriced and the cost report itself had been brought to final settlement.

⁵ 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.

⁶ 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.

⁷ 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)).

CMS Changes in the Hospital Outlier Payment Reconciliation Methodology

Outlier Payment Reconciliation

CMS developed new outlier regulations⁸ and guidance in 2003 after reporting that, from Federal FYs 1998 through 2002, it paid approximately \$9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.^{9, 10} The 2003 regulations 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 reprice submitted claims and allow Medicare contractors to settle cost reports.¹¹

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 differ 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 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 (*Medicare Claims Processing Manual (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."

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 707¹² provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until

⁸ 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 (Jun. 9, 2003).

⁹ CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003).

¹⁰ 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.

¹¹ 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.

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

April 1, 2011. In CMS Transmittal 2111,¹³ 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 also 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 reconciliation¹⁴ 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 exists to help Medicare contractors perform reconciliations and process cost reports. Medicare contractors use the Fiscal Intermediary Standard System (FISS) Lump Sum Utility to perform the 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 FY 2006 and FY 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 FY 2008 and FY 2009 SSI ratios. The DSH/SSI hold remained in effect until CMS published the updated SSI ratios in June 2012.

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 Cahaba 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

¹³ 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).

¹⁴ CMS uses the term “flagged” to refer to outlier payments whose reconciliations were backlogged between 2005 and April 1, 2011.

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 13 cost reports with outlier payments that qualified for reconciliation, Cahaba referred 5 cost reports to CMS in accordance with Federal guidelines. However, Cahaba did not refer eight cost reports that should have been referred to CMS for reconciliation. Of these eight, Cahaba had referred and reconciled the outlier payments associated with one cost report after we started our audit. The remaining seven cost reports had not been settled and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between the outlier payments associated with the seven cost reports and the recalculated outlier payments totaled at least \$8,488,306. We refer to this difference as "financial impact."¹⁵

Of the five cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Cahaba had reconciled the outlier payments associated with three cost reports by December 31, 2011. However, Cahaba had not reconciled the outlier payments associated with the remaining two cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with one of the two cost reports that were referred but not reconciled was \$601,785 that was due to Medicare. The remaining cost report had been settled and had exceeded the 3-year reopening limit. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with this cost report was at least \$532,970 that may be due to Medicare.

Because we could not verify the original outlier payment calculation, we were unable to recalculate 1 of the 477 claims associated with the cost reports that we were recalculating and are setting aside \$113,613¹⁶ in outlier payments associated with that claim for resolution by Cahaba and CMS.

See Appendix C for a summary of the status of the 13 cost reports with respect to referral and reconciliation, as well as the associated dollar amounts due to Medicare or to providers.

¹⁵ 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.

¹⁶ This amount is separate from the financial impact amounts mentioned in the two immediately preceding paragraphs.

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 make 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).

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 13 cost reports with outlier payments that qualified for reconciliation, Cahaba referred 5 cost reports to CMS in accordance with Federal guidelines. However, Cahaba did not refer eight cost reports that should have been referred to CMS for reconciliation.

Of the eight cost reports that Cahaba did not refer to CMS for reconciliation according to Federal guidelines, Cahaba had referred and reconciled the outlier payments associated with one cost report after we started our audit. However, seven cost reports had not been settled and should have been referred to CMS for reconciliation. Because Cahaba 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 seven cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these seven unrefereed cost reports totaled at least \$8,488,306 that was due to Medicare.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the five referred cost reports whose outlier payments qualified for reconciliation, Cahaba reconciled the outlier payments associated with three cost reports by December 31, 2011. However, Cahaba did not reconcile the outlier payments associated with two cost reports by December 31, 2011.

Cost Report Within the 3-Year Reopening Limit

Of the two referred cost reports whose outlier payments Cahaba did not reconcile by December 31, 2011, one cost report was on hold because CMS had not calculated revised SSI ratios. CMS bore principal responsibility for this delay. For this cost report, the financial impact of the outlier payments was \$601,785 that was due to Medicare.

Cost Report Outside the 3-Year Reopening Limit

Of the two referred cost reports whose outlier payments Cahaba did not reconcile by December 31, 2011, one cost report had been settled and had exceeded the 3-year reopening limit because the Medicare contractor previous to Cahaba did not correctly perform the reconciliation test and erroneously concluded that this cost report did not meet the criteria for reconciliation. The cost report was brought to final settlement without its outlier payments being reconciled. Later, the Medicare contractor previous to Cahaba reperformed the reconciliation test and referred this cost report to CMS for reconciliation, but it failed to reopen the cost report. Because the cost report was settled and the 3-year reopening limit had expired, Cahaba was unable to reconcile the outlier payments associated with this cost report. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with this cost report totaled at least \$532,970 that may be due to Medicare.

CLAIMS THAT COULD NOT BE RECALCULATED

The seven unrefereed cost reports with unreconciled outlier payments included one claim with \$113,613 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 \$113,613 for resolution by Cahaba and CMS. We are separately providing to Cahaba detailed data on the claim that we could not recalculate.

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with the seven unrefereed cost reports that were within the 3-year reopening limit was at least \$8,488,306 that was due to Medicare. 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, for one referred cost report within the 3-year reopening limit whose outlier payments Cahaba did not reconcile by December 31, 2011, the financial impact of those outlier payments was \$601,785 that was due to Medicare.

Finally, for one referred cost report that exceeded the 3-year reopening limit and whose outlier payments Cahaba did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least \$532,970 that may be due to Medicare.

RECOMMENDATIONS

We recommend that Cahaba:

- review the seven 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, request CMS approval to recoup at least \$8,488,306 in funds and associated interest from health care providers, and refund that amount to the Federal Government;
- review one cost report that was referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$601,785 in associated outlier payments due to the Federal Government, finalize this cost report, and ensure that the provider returns the funds to Medicare;
- review one cost report that had been referred to CMS, had been settled, had exceeded the 3-year reopening limit, and had outlier payments that qualified for reconciliation, determine whether this cost report may be reopened, and work with CMS to resolve at least \$532,970 in funds and associated interest from the health care provider that may be due to the Federal Government;
- work with CMS to resolve the \$113,613 in outlier payments associated with one claim that we could not recalculate;
- ensure 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 policies and procedures are in place so that it 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, Cahaba generally concurred with all of our recommendations and described corrective actions that it had taken or planned to take.

Regarding the cost report that had exceeded the 3-year reopening limit (our third recommendation), Cahaba stated that this cost report was incorrectly settled by a prior Medicare contractor. Cahaba was unable to initiate a cost reopening because the 3-year reopening limit from the date of the original NPR had elapsed. As a result, CMS disapproved Cahaba's request to reconcile outlier payments.

Cahaba's comments appear in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

With respect to the cost report associated with our third 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., Cahaba) 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 third recommendation and recognize that ultimately, CMS as the cognizant Federal agency has the authority to decide how to resolve the recommendations in this report. Accordingly, we continue to recommend that Cahaba determine whether the provider associated with this cost report procured Medicare funds by "similar fault" and work with CMS to resolve its \$532,970 in outlier payments.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>First Coast Service Options, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00022	3/XX/2015
<i>Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02774	12/16/2014
<i>Wisconsin Physicians Service Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02777	11/18/2014
<i>Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-11-02773	10/29/2014
<i>Trailblazer Health Enterprises Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required</i>	A-07-10-02776	6/10/2014
<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	6/28/2012

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 Cahaba 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, 2011.¹⁷ 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 calculated the amounts due to Medicare or to providers.

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

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to Cahaba and other Medicare contractors concerning the reconciliation process and responsibilities;
- obtained from CMS a list of cost reports that Medicare contractors had referred for reconciliation;
- held discussions with Cahaba officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed Cahaba'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 Cahaba's jurisdiction as of October 29, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that Cahaba had referred to CMS for reconciliation during our audit period;
- obtained the cost report data from CMS's database for cost reports with FY ends during our audit period;

¹⁷ 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 the Inpatient Acute Care and LTCH provider-specific files 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 payments¹⁸ and
 - using the information in CMS’s database and provider-specific file 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 Cahaba used the three different types of outlier payments specified by Federal regulations¹⁹ (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;
- requested that Cahaba provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;²⁰
- reviewed Cahaba’s response and categorized the cost reports according to their respective statuses;
- verified whether Cahaba 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 Cahaba did not recalculate the outlier payments:
 - obtained the detailed Provider Statistical & Reimbursement reports from Cahaba;
 - verified the original outlier payments using the CCR that was used to pay the claim;²¹
 - recalculated the outlier payment amounts for those cost reports that Cahaba did not recalculate using the actual CCR;

¹⁸ CMS cost report data included operating and capital payments but did not include short-stay outlier payments.

¹⁹ Claims Processing Manual, chapter 3, § 20.1.2.5.

²⁰ Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by Cahaba.

²¹ We set aside claims for which we could not verify their original outlier payments.

- identified one claim that we were unable to recalculate because we could not verify the original outlier payment calculation for that claim; and
- calculated accrued interest²² 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 Cahaba officials on March 4, 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.

²² We calculated interest by referring to the Claims Processing Manual, § 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
13 cost reports	\$11,858,888	\$2,368,226

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	1	3	4	0	7	8
Balance due to Medicare	\$353,960	\$3,379,310	\$3,900,695	\$0	\$7,280,005	\$7,633,965
Interest due to Medicare	46,548	721,300	487,001	0	1,208,301	1,254,849
Balance due to provider	0	0	0	0	0	0
Interest due to provider	0	0	0	0	0	0
Total due to Medicare	\$400,508	\$4,100,610	\$4,387,696	\$0	\$8,488,306	\$8,888,814
Total due to provider	\$0	\$0	\$0	\$0	\$0	\$0

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

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	3	0	1	1	2	5
Balance due to Medicare	\$1,704,580	\$0	\$541,975	\$495,957	\$1,037,932	\$2,742,512
Interest due to Medicare	130,739	0	59,810	37,013	96,823	227,562
Balance due to provider	2,146,437	0	0	0	0	2,146,437
Interest due to provider	221,789	0	0	0	0	221,789
Total due to Medicare	\$1,835,319	\$0	\$601,785	\$532,970	\$1,134,755	\$2,970,074
Total due to provider	\$2,368,226	\$0	\$0	\$0	\$0	\$2,368,226

APPENDIX D: AUDITEE COMMENTS



December 18, 2014

US Department of Health and Human Services
Office of the Inspector General
Office of Audit Services, Region V
Attention: Sheri L. Fulcher, Regional Inspector General for Audit Services
233 North Michigan, Suite 1360
Chicago, IL 60601

RE: Cahaba Government Benefit Administrators®, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments (Report Number: A-05-11-00019)

Dear Ms Fulcher:

We appreciate the opportunity to respond to the above mentioned draft report. Cahaba has reviewed the report and its response to each recommendation is as follows:

1. Review the seven 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, request CMS approval to recoup at least \$8,488,306 in funds and associated interest from health care providers, and refund that amount to the Federal Government.

Cahaba's Response: *Seven of seven cost reports which had not been settled (due to CMS settlement hold for SSI) have been referred to CMS for approval to reconcile outlier payments. There are actually six cost reports impacted since one cost report contains an attached Inpatient Rehabilitation Facility (IRF) T-Unit sub-provider which qualifies for outlier reconciliation. Of the six cost reports impacted, three were subsequently approved by CMS for the reconciliation of outlier payments and included in the final settlement. For the other three cost reports Cahaba has not received CMS' approval to proceed with reconciliation of the outlier payments. In November, Cahaba sent notification to CMS to confirm nine outstanding cost reports for which approval for the reconciliation of outlier payments has previously been requested from CMS, yet the requests remain unanswered to date. Cahaba cannot proceed with the finalization of the cost report settlements, to include reconciled outlier payments, until CMS' approval has been granted.*

Cahaba Government Benefit Adm. - Insurers, LLC
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A CMS Medicare Administrative Contractor



2. Review one cost report that was referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$601,785 in associated outlier payments due to the Federal Government, finalize this cost report, and ensure that the provider returns the funds to Medicare.

Cahaba's Response: *A cost report reopening was completed and the revised Notice of Reimbursement (NPR) was issued 06/14/2013, to address the \$601,785 in recoupment of overpayment due back to Medicare.*

3. Review one cost report that had been referred to CMS, had been settled, had exceeded the 3-year reopening limit, and had outlier payments that qualified for reconciliation; determine whether this cost report may be reopened, and work with CMS to resolve at least \$532,970 in funds and associated interest from the health care provider that may be due to the Federal Government.

Cahaba's Response: *As previously disclosed to the OIG during their review, a cost report was incorrectly settled by a prior fiscal intermediary (FI) prior to the transition of J-19 to Cahaba. The provider was subsequently determined to qualify for outlier reconciliation. By the time Cahaba was made aware the three-year window from the date of the original NPR (issued in error by the prior FI) had elapsed, eliminating the ability of Cahaba to initiate a cost report reopening to address the reconciliation of outlier payments. CMS also approved Cahaba's request to reconcile outlier payments on this basis on 09/12/2011.*

4. Work with CMS to resolve the \$113,613 in outlier payments associated with one claim that we could not recalculate.

Cahaba's Response: *The cost report identified by the OIG with set-aside claims of \$113,613 remains unapproved to-date by CMS to reconcile outlier payments. This cost report is one of the nine cost reports recently referred to CMS in early November by Cahaba.*

5. Ensure 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.

Cahaba's Response: *The Contractor's Audit Final Settlement/Reopening Checklist has been revised to include a step requiring sign-off by the Audit Staff to document the review of outlier payments relative to the CMS-established threshold. In any instances where settled cost reports have been identified as*



qualifying for outlier reconciliation a reopening of the cost report has been initiated by Cahaba pending receipt of CMS' approval.

6. Ensure policies and procedures are in place so that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines.

Cahaba's Response: *Updated procedures regarding the review of PPS hospital cost reports (including inpatient rehabilitation (IRR) and psychiatric (IPF) facility subproviders) were distributed to the Audit Staff via email on 07/31/2013. Written procedures will be added to Cahaba's International Organization for Standardization (ISO) Level III Desk Procedures to ensure that all referred cost reports which are identified to qualify for the reconciliation of outlier payments are reconciled in conformance with CMS' instructions.*

7. 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.

Cahaba's Response: *All applicable hospital cost reports which have been submitted to Cahaba subsequent to the end of the OIG's audit have been subject to review prior to settlement (issuance of the NPR) to determine if the provider qualified for the reconciliation of outlier payments. They then have been referred to CMS in all cases where qualifying thresholds were determined to have been exceeded.*

If you should have any questions regarding this report, please contact me at (205) 220-1957 (lbramer@cahabagba.com) or Daniele Greene at (205)220-1385 (dgreene@cahabagba.com).

Sincerely,

Lisa Bramer
Internal Audit Manager
Cahaba Government Benefit Administrators®, LLC

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A CMS Medicare Administrative Contractor