

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
IN JURISDICTION 8**

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Office of Inspector General

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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 \$2.1 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), had been since 2009 the Medicare contractor for Jurisdiction 8, which comprises Indiana and Michigan. In August 2012, NGS's responsibilities transitioned to Wisconsin Physicians Service Insurance Corporation (WPS); accordingly, we are addressing our recommendations to WPS.

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. 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 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 18 cost reports with outlier payments that qualified for reconciliation, NGS referred 11 cost reports to CMS in accordance with Federal guidelines. However, NGS did not refer seven cost reports that should have been referred to CMS for reconciliation. Of these seven, one cost report had not been settled and should have been referred to CMS for reconciliation. As of December 31, 2011, the difference between the outlier payments associated with this cost report and the recalculated outlier payments was \$2,102,430. We refer to this difference as "financial impact." The six 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 the financial impact of the outlier payments associated with those six cost reports totaled at least \$6,096,595.

Of the 11 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, NGS had reconciled the outlier payments associated with five cost reports by December 31, 2011. However, NGS had not reconciled the outlier payments associated with the remaining six cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with these six cost reports that were referred but not reconciled was \$10,855,073.

Because we could not verify the original outlier payment calculation, we were unable to recalculate 20 of the 409 claims associated with the cost reports that we were recalculating and are setting aside \$236,099 in outlier payments associated with those claims for resolution by WPS and CMS.

WHAT WE RECOMMEND

We recommend that WPS:

- review the cost report that had not been settled and should have been referred to CMS for reconciliation but was not, take appropriate actions to refer this cost report, request CMS approval to recoup \$2,102,430 in funds and associated interest from the health care provider, and refund that amount to the Federal Government;
- review the 6 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 at least \$6,096,595 in

funds and associated interest from health care providers that may be due to the Federal Government;

- review the 6 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$10,855,073 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare;
- work with CMS to resolve the \$236,099 in outlier payments associated with the 20 claims 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 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, WPS concurred with all but one of our recommendations and described corrective actions that it had taken or planned to take. Our draft report had a recommendation regarding the 26 claims that we could not recalculate. However, WPS stated that there were only 20 claims. The remaining 6 claims did not need to be recalculated because they were not the final adjusted claims.

After reviewing WPS's comments and the supporting documentation for the 26 claims that we could not recalculate, we agree that 6 of these claims were not the final adjusted claims. We corrected our finding and recommendation.

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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), had been since 2009 the Medicare contractor for Jurisdiction 8, which comprises Indiana and Michigan. In August 2012, NGS's responsibilities transitioned to Wisconsin Physicians Service Insurance Corporation (WPS); accordingly, we are addressing our recommendations to WPS.

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 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 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)). 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 the hospital.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 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 complete if all claims had been correctly re-priced 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 may 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 re-price 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 FYs 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 FYs 2008 and 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 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

¹³ CMS, *Outlier Reconciliation and Other Outlier Manual Updates for IPPS, OPPOS [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 18 cost reports with outlier payments that qualified for reconciliation, NGS referred 11 cost reports to CMS in accordance with Federal guidelines. However, NGS did not refer seven cost reports that should have been referred to CMS for reconciliation. Of these seven, one cost report had not been settled and should have been referred to CMS for reconciliation. As of December 31, 2011, the difference between the outlier payments associated with this cost report and the recalculated outlier payments was \$2,102,430. We refer to this difference as "financial impact."¹⁵ The six 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 the financial impact of the outlier payments associated with those six cost reports totaled at least \$6,096,595.

Of the 11 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, NGS had reconciled the outlier payments associated with five cost reports by December 31, 2011. However, NGS had not reconciled the outlier payments associated with the remaining six cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with these six cost reports that were referred but not reconciled was \$10,855,073.

Because we could not verify the original outlier payment calculation, we were unable to recalculate 20 of the 409 claims associated with the cost reports that we were recalculating and are setting aside \$236,099¹⁶ in outlier payments associated with those claims for resolution by WPS and CMS.

See Appendix C for a summary of the status of the 18 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 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).

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 18 cost reports with outlier payments that qualified for reconciliation, NGS referred 11 cost reports to CMS in accordance with Federal guidelines. However, NGS did not refer seven cost reports that should have been referred to CMS for reconciliation.

Cost Report Within the 3-Year Reopening Limit

Of the seven cost reports that NGS did not refer to CMS for reconciliation, one 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 this cost report. As of December 31, 2011, the financial impact of the outlier payments associated with this unrefereed cost report was \$2,102,430 that was due to Medicare.

Cost Reports Outside the 3-Year Reopening Limit

Of the seven cost reports that NGS did not refer to CMS for reconciliation, the remaining six cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. 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, NGS did not perform the reconciliation test to identify and refer six cost reports that qualified for reconciliation. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these six cost reports totaled at least \$6,096,595 that may be due to Medicare.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 11 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, NGS had reconciled the outlier payments associated with five cost reports by December 31, 2011. However, NGS had not reconciled the outlier payments associated with the remaining six cost reports. The statuses of the cost reports with unreconciled outlier payments were as follows:

- two cost reports were on hold because CMS had not calculated revised SSI ratios¹⁷ (CMS bore principal responsibility for the delays¹⁸); and
- four cost reports received CMS approval and were undergoing the reconciliation process. For these cost reports, NGS's policies and procedures did not ensure that it reconciled all outlier payments associated with all referred cost reports that qualified for reconciliation in accordance with Federal guidelines.

For the six referred cost reports whose outlier payments NGS did not reconcile by December 31, 2011, the financial impact of the outlier payments was \$10,855,073 that was due to Medicare.

CLAIMS THAT COULD NOT BE RECALCULATED

To determine the financial impact of the six unreferred cost reports that had exceeded the 3-year reopening limit, we attempted to recalculate 409 claims related to these cost reports. However, we were unable to recalculate 20 claims with \$236,099 in associated outlier payments because we could not verify the original outlier payment calculation. We are therefore setting aside the \$236,099 for resolution by WPS and CMS. We are separately providing detailed data on the claims that we could not recalculate to WPS.

¹⁷ These two cost reports were on hold because of the SSI-related issue discussed in "Background."

¹⁸ We will report to CMS on issues related to cost report referral and outlier payment reconciliation in a future review.

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with one unreferred cost report that was within the 3-year reopening limit was \$2,102,430 that was due to Medicare. This cost report should have been referred to CMS for reconciliation but was not and was also not reconciled even though its outlier payments qualified for reconciliation.

Also as of December 31, 2011, the financial impact of the outlier payments associated with the six 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 \$6,096,595 that may be due to Medicare.

Finally, for the six referred cost reports whose outlier payments NGS did not reconcile by December 31, 2011, the financial impact of those outlier payments was \$10,855,073 that was due to Medicare.

RECOMMENDATIONS

We recommend that WPS:

- review the cost report that had not been settled and should have been referred to CMS for reconciliation but was not, take appropriate actions to refer this cost report, request CMS approval to recoup \$2,102,430 in funds and associated interest from the health care provider, and refund that amount to the Federal Government;
- review the 6 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 at least \$6,096,595 in funds and associated interest from health care providers that may be due to the Federal Government;
- review the 6 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$10,855,073 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare;
- work with CMS to resolve the \$236,099 in outlier payments associated with the 20 claims 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 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, WPS concurred with all but one of our recommendations and described corrective actions that it had taken or planned to take.

Our draft report had a recommendation regarding the 26 claims that we could not recalculate. However, WPS stated that there were only 20 claims. The remaining 6 claims did not need to be recalculated because they were not the final adjusted claims.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing WPS's comments and the supporting documentation for the 26 claims that we could not recalculate, we agree that 6 of these claims were not the final adjusted claims. We corrected our finding and recommendation.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<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 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, 2011.¹⁹ 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 our audit work in our Chicago, Illinois, regional office from November 2010 to July 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 responsibilities;
- 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;²⁰
- obtained and reviewed the list of cost reports, with supporting documentation, that NGS had referred to CMS for reconciliation during our audit period;

¹⁹ 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.

²⁰ During our fieldwork, some health care providers transitioned from one Medicare contractor to another. We established August 1, 2012, as our cutoff date to determine what Medicare contractor our findings should be addressed to.

- obtained the cost report data from CMS’s database for cost reports with FY ends during our audit period;
- 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 payments²¹ 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 NGS used the three different types of outlier payments specified by Federal regulations²² (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;²³
- 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;²⁴

²¹ CMS cost report data included operating and capital payments but did not include short-stay outlier payments.

²² Claims Processing Manual, chapter 3, § 20.1.2.5.

²³ Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by NGS.

²⁴ 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 those claims that we were unable to recalculate because we could not verify the original outlier payment calculation for particular claims; and
 - calculated accrued interest²⁵ 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 WPS officials on July 2, 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.

²⁵ 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
18 Cost Reports	\$32,460,493	\$962,698

Table 2: Cost Reports Not Referred (OIG Identified)

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		Past 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
Number of cost reports	0	1	0	6	7	7
Balance due to Medicare	\$0	\$1,755,432	\$0	\$4,649,497	\$6,404,929	\$6,404,929
Interest due to Medicare	0	346,998	0	1,447,098	1,794,096	1,794,096
Total due to Medicare	\$0	\$2,102,430	\$0	\$6,096,595	\$8,199,025	\$8,199,025

Note: The dollar amounts associated with these cost reports do not reflect the 20 claims that we were unable to recalculate.

Table 3: Cost Reports Referred (Medicare Contractor Identified)

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		Past 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
Number of cost reports	5	4	2	0	6	11
Balance due to Medicare	\$12,552,717	\$3,543,358	\$6,709,614	\$0	\$10,252,972	\$22,805,689
Interest due to Medicare	853,678	389,162	212,939	0	602,101	1,455,779
Balance due to provider	701,751	0	0	0	0	701,751
Interest due to provider	260,947	0	0	0	0	260,947
Total due to Medicare	\$13,406,395	\$3,932,520	\$6,922,553	\$0	\$10,855,073	\$24,261,468
Total due to provider	\$962,698	\$0	\$0	\$0	\$0	\$962,698

APPENDIX D: AUDITEE COMMENTS



Medicare

2/12/2014

Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
255 North Michigan, Suite 1350
Chicago, IL 60601

RE: Office of Inspector General (OIG) Draft Report – A-05-14-00046

Dear Ms. Fulcher,

This letter is in response to the OIG draft report titled *National Government Service, Inc. Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 8*.

OIG compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2008, and December 31, 2008, to determine whether National Government Service, Inc. (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.

Of 18 cost reports with outlier payments that qualified for reconciliation, NGS referred 11 cost reports to CMS in accordance with Federal guidelines. However, NGS did not refer seven cost reports that should have been referred to CMS for reconciliation. Of these seven, one cost report had not been settled and should have been referred to CMS for reconciliation. As of December 31, 2011, the difference between the outlier payments associated with this cost report and the recalculated outlier payments was \$2,192,430. We refer to this difference as "financial impact". The six remaining cost reports had been settled, had exceeded the 3-year reporting limit, and should have been referred to CMS for reconciliation. We estimated that the financial impact of the outlier payments associated with these six cost reports totaled at least \$6,095,295.

Of the 11 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, NGS had reconciled the outlier payments associated with five cost reports by December 31, 2011. However, NGS had not reconciled the outlier payments associated with the remaining six cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with these six cost reports that were referred but not reconciled was \$10,555,072.

Because we could not verify the original outlier payment calculation, we were unable to recalculate 25 of the 495 claims associated with the cost reports that we were recalculating and are setting aside \$236,099 in outlier payments associated with these claims for resolution by WPS and CMS.

OIG Recommendations to WPS and WPS' response to Recommendations:

- review the cost report that had not been settled and should have been referred to CMS for reconciliation but was not, take appropriate actions to refer this cost report, request CMS approval to recoup \$2,192,430 in funds and associated interest from the health care provider, and refund that amount to the Federal government;



Wisconsin: First Wisconsin Service Insurance Corporation acting as a CMS Medicare Contractor
P.O. Box 1737 • Madison, WI 53701 • Phone 608-221-4711

- review the 6 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; determining whether these cost reports may be reopened; work with CMS to resolve at least \$6,096,395 in funds and associated interest from health care providers that may be due to the Federal Government;
- review the 6 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$10,855,673 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare;
- work with CMS to resolve the \$226,359 in outlier payments associated with the 26 claims 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 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.

WPS Response to the OIG Recommendations:

- review the cost report that had not been settled and should have been referred to CMS for reconciliation but was not; take appropriate actions to refer this cost report, request CMS approval to recoup \$2,102,430 in funds and associated interest from the health care provider, and refund that amount to the Federal government;

WPS Response:

Regarding the cost report in question, a revised final settlement was issued by NGS on May 18, 2012, for the purpose of recouping \$2,102,430 in outlier reconciliation and associated interest.

- review the 6 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; determining whether these cost reports may be reopened; work with CMS to resolve at least \$6,096,395 in funds and associated interest from health care providers that may be due to the Federal Government;

WPS Response:

The Medicare regulations at 42 CFR 405.1885(b) state:

- (b) Time limits – (1) *Own motion reopening of a determination not procured by fraud or similar fault.* An own motion reopening is timely only if the notice of intent to reopen (as described in §405.1887 of this subpart) is issued no later than 3 years after the date of the determination or decision that is the subject of the

reopening. The date the notice is mailed is presumed to be the date indicated on the notice unless it is shown by a preponderance of the evidence that the notice was mailed on a later date.

As the 3-year reopening period has lapsed on all 6 of the cost reports in question, WPS is prohibited by the Medicare regulations from reopening any of these cost reports in order to refer the outlier reconciliations to CMS and recover any funds resulting from these reconciliations. However, WPS will work with CMS to review the specific circumstances for each provider to determine if the "similar fault" regulations should apply.

- *review the 6 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$10,855,073 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare.*

WPS Response:

Of the 6 cost reports that have been referred, 4 have been settled with a total of \$3,954,520 in associated outlier payments and interest recovered and returned to Medicare. Of those not settled, WPS is waiting for an initial approval from CMS to perform the reconciliation on one and is waiting for clarification from CMS regarding the time value of money calculation on the other. WPS has been in regular contact with CMS regarding the status of these 2 cost reports.

- *work with CMS to resolve the \$276,099 in outlier payments associated with the 26 claims that OIG could not recalculate;*

WPS Response:

In reviewing the list of claims that OIG could not recalculate we noted that there are actually only 20 claims to be recalculated. 3 of these claims were adjusted and OIG has included the original claim record, the credit adjustment claim record and the final adjusted claims in its listing for these 3 claims. In this situation only the final adjusted claim would need to be recalculated, therefore 6 of the claim records do not need to be recalculated. We also note these 20 claims are associated with a cost report that is currently beyond the allowable 3-year reopening period (see above), so any attempt to recalculate these claims at this point would likely be futile. However, WPS will work with CMS to review the specific circumstances for this provider to determine if the "similar fault" regulations should apply. If we determine the similar fault regulations do apply, WPS will recalculate the 20 impacted claims.

- *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;*

WPS Response:

Currently WPS has in place specific work instructions, forms and checklists designed to ensure that all cost reports are reviewed prior to final settlement to identify those that qualify for outlier reconciliation and properly referred to CMS for their approval prior to processing the final settlement. These procedures have been reviewed periodically and in response to clarifications and are currently up to date.

- *ensure that 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*

WPS Response:

Currently WPS has in place specific work instructions, forms and checklists designed to ensure that all outlier payments associated with cost reports that qualify for a reconciliation are reconciled prior to final settlement. These procedures have been reviewed periodically and in response to clarifications and are currently up to date. WPS has been actively involved with the system maintenance to identify issues with the FISS Lump Sum Utility and to assist with resolving those issues to ensure that reconciliations are performed timely and accurately.

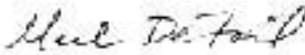
- *review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.*

WPS Response:

All cost reports submitted since the end of the audit period have been or will be reviewed as part of our final settlement process in accordance with our control procedures.

If you have any questions or need additional information, please contact me at 402-955-0443.

Sincerely,



Mark DeFoil
Director, Contract Administration

Cc: Konda Jones, CMS
Wanda Jones, CMS
Robert Bernal, CMS
James Massa, CMS
Stephen Slamer, OIG