

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PALMETTO GOVERNMENT BENEFITS  
ADMINISTRATOR DID NOT ALWAYS  
REFER MEDICARE COST REPORTS  
AND RECONCILE OUTLIER  
PAYMENTS IN JURISDICTION 1**

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Inspector General

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

***Palmetto Government Benefits Administrator 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 \$2.9 million that should be recouped from health care providers and returned to Medicare. In addition, Palmetto 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, Palmetto Government Benefits Administrator (Palmetto), had been since 2008 the Medicare contractor for Jurisdiction 1, which comprises the States of California, Hawaii, and Nevada and the territories of American Samoa, Guam, and the Northern Mariana Islands. In August 2013, Palmetto's responsibilities transitioned to Noridian Healthcare Solutions, LLC (Noridian); accordingly, we are addressing our recommendations to Noridian.

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

### BACKGROUND

CMS administers Medicare and uses a prospective payment system to pay Medicare-participating hospitals (hospitals) for providing inpatient hospital services to Medicare beneficiaries. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.

Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses due to unusually high-cost cases. Medicare contractors calculate outlier payments on the basis of claim submissions made by hospitals and by using hospital-specific cost-to-charge ratios (CCRs). Medicare contractors review cost reports that hospitals have submitted, make any necessary adjustments, and determine whether payment is owed to Medicare or to the 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 Palmetto 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 72 cost reports with outlier payments that qualified for reconciliation, 45 cost reports had unreliable CCRs because their cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed; we discuss these 45 cost reports below. Of the 27 remaining cost reports with outlier payments that qualified for reconciliation, Palmetto referred 22 cost reports to CMS in accordance with Federal guidelines. However, Palmetto did not refer five cost reports that should have been referred to CMS for reconciliation. Of these, one cost report had not been settled and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with this cost report and (2) the recalculated outlier payments totaled at least \$2,978,002. We refer to this difference as financial impact. The four remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation; the financial impact of the outlier payments associated with those four cost reports totaled \$7,279,329.

Of the 22 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Palmetto had reconciled the outlier payments associated with 6 cost reports by December 31, 2011. However, Palmetto had not reconciled the outlier payments associated with the remaining 16 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 15 of the 16 cost reports that were referred but not reconciled was at least \$49,534,505. We also calculated that \$4,038,751 was due from Medicare to a provider for 1 of the 16 cost reports that were referred but not reconciled. The net financial impact of the outlier payments associated with these 16 cost reports that were referred but not reconciled was therefore at least \$45,495,754 that was due to Medicare.

Because certain providers require specialized recalculations for their outlier payments, we were unable to recalculate 133 of the 592 claims associated with the cost reports that we were recalculating and are setting aside \$1,142,434 in outlier payments associated with those claims for resolution by Noridian and CMS.

Of the 45 cost reports that qualified for reconciliation and that had unreliable CCRs:

- Palmetto did not refer 28 cost reports that should have been referred to CMS for reconciliation. Of these unreferred cost reports, 11 had not been settled, whereas 17 had been settled and had exceeded the 3-year reopening limit. These 28 cost reports included 24,437 claims and \$34,897,819 in associated outlier payments.

- Palmetto referred the other 17 cost reports that had unreliable CCRs to CMS in accordance with Federal guidelines, but it had not reconciled the outlier payments associated with any of these cost reports by December 31, 2011. These 17 cost reports included 9,555 claims and \$15,792,301 in associated outlier payments.

Because CMS had not resolved the issues related to the reconciliation of cost reports with unreliable CCRs, we were unable to calculate the financial impact for these cost reports and are setting aside the associated 33,992 claims (24,437 + 9,555) and \$50,690,120 in outlier payments (\$34,897,819 + \$15,792,301) for resolution by Noridian and CMS.

## **WHAT WE RECOMMEND**

We recommend that Noridian:

- review the 1 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 \$2,978,002 in funds and associated interest from a health care provider, and refund that amount to the Federal Government;
- review the 4 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 \$7,279,329 in funds and associated interest from health care providers that may be due to the Federal Government;
- review the 16 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
  - reconcile the \$49,534,505 in associated outlier payments due to the Federal Government (15 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare, and
  - reconcile the \$4,038,751 in associated outlier payments due from Medicare to a provider (1 cost report), finalize that cost report, and return the funds to the provider;
- work with CMS to resolve the \$1,142,434 in outlier payments associated with the 133 claims that we could not recalculate;
- review the 28 cost reports with unreliable CCRs that should have been referred to CMS for reconciliation but were not, take appropriate actions to refer the 11 cost reports that had not been settled, determine whether the other 17 cost reports that had exceeded the 3-year reopening limit may be reopened, and work with CMS to resolve the \$34,897,819 in outlier payments associated with these 28 cost reports that we could not recalculate;

- review the 17 cost reports with unreliable CCRs that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to resolve the \$15,792,301 in outlier payments associated with these cost reports that we could not recalculate;
- ensure that control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;
- ensure that policies and procedures are in place so that 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**

### **Auditee Comments**

In written comments on our draft report, Noridian concurred with our first recommendation and with the findings associated with our third recommendation (the 16 referred cost reports whose outlier payments qualified for reconciliation) and our sixth recommendation (the 17 referred cost reports with unreliable CCRs whose outlier payments qualified for reconciliation). Noridian also described corrective actions that it had taken or planned to take with respect to these three recommendations.

Noridian did not specifically agree or disagree with our fourth recommendation but said that it would work with CMS to resolve the \$1,142,434 in outlier payments associated with the 133 claims that we could not recalculate. Noridian also did not specifically agree or disagree with our last three recommendations, which are procedural. With respect to our final recommendation, Noridian said that it would review all cost reports (submitted since the end of our audit period) within the 3-year reopening limit and reopen them “as resources allow.”

Noridian partially concurred with our second recommendation regarding the four cost reports that had exceeded the 3-year reopening limit and should have been referred to CMS but were not. Noridian stated that it had determined that one of the four cost reports should have been referred to CMS. Noridian also said that it was not aware of any regulation that would allow it to reopen these four cost reports but added that it would discuss this issue with CMS.

Noridian made the same comment with respect to the 17 unreferred cost reports (of the 28 unreferred cost reports with unreliable CCRs that form the basis of our fifth recommendation) that had exceeded the 3-year reopening limit. Noridian added that it had determined that 2 of these 17 cost reports met the criteria for reconciliation. With respect to the other 11 unreferred cost reports with unreliable CCRs (of the 28 cost reports that our fifth recommendation

addresses), Noridian concurred with our findings regarding—and provided updated information on the referral status of—10 of those 11 cost reports. For the other cost report (of those 11), Noridian said that the previous Medicare contractor had settled it after using a different method to calculate its CCR and, according to Noridian, had then determined that referral was not required for that cost report.

## **Our Response**

After reviewing Noridian’s comments, we maintain that all of our findings and recommendations remain valid.

For the cost reports discussed in our second and fifth recommendations, the information that Noridian provided regarding the referral status of certain cost reports agreed with our own analysis of their status. After receiving Noridian’s comments, we also reevaluated the cost reports discussed in those two recommendations and reverified that those cost reports met the criteria for reconciliation of outlier payments.

With respect to all of the cost reports that, as mentioned in our second and fifth recommendations, 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.” Moreover, we continue to recommend that the 1 cost report (of the other 11 unreferred cost reports with unreliable CCRs that our fifth recommendation addresses) that, according to Noridian, had been settled by the previous Medicare contractor be referred to CMS as well. The circumstances under which a Medicare contractor may use a different method to calculate a cost report’s CCR are very limited and do not extend to the procedures required to determine whether the cost report qualifies for referral.

With respect to our final recommendation—that Noridian review all cost reports submitted since the end of our audit period and ensure those whose outlier payment qualified for reconciliation are referred and reconciled in accordance with Federal guidelines—Noridian said that it would do so, as resources allow, for all cost reports within the 3-year reopening limit. We continue to recommend that, in conformance with Federal requirements, Noridian review all cost reports submitted since the end of our audit period, including those that exceed the 3-year reopening limit, and work with CMS to determine whether those cost reports can be reopened under the “fraud or similar fault” provision discussed above.

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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.<sup>1</sup> 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.<sup>2</sup> 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 (Appendix A) 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. One such contractor, Palmetto Government Benefits Administrator (Palmetto), had been since 2008 the Medicare contractor for Jurisdiction 1, which comprises the States of California, Hawaii, and Nevada and the territories of American Samoa, Guam, and the Northern Mariana Islands. In August 2013, Palmetto's responsibilities transitioned to Noridian Healthcare Solutions, LLC (Noridian); accordingly, we are addressing our recommendations to Noridian.

### OBJECTIVES

Our objectives were to determine whether Palmetto (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.<sup>3</sup>

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<sup>1</sup> 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.

<sup>2</sup> *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.

<sup>3</sup> 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 accurately reflect 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 when 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)).<sup>4</sup> More than one CCR can be used in a cost-reporting period.

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

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<sup>4</sup> These regulations effectively eliminated the use of the statewide average CCR for hospitals with a CCR that falls below the former CMS-established thresholds.

because of one of the following circumstances: a new hospital has not yet submitted its first Medicare cost report, a hospital's CCR is in excess of three standard deviations above the corresponding national geometric mean,<sup>5</sup> or the Medicare contractor cannot obtain accurate data to calculate a CCR. Alternatively, the Medicare contractor can use a CMS-approved alternative CCR to calculate and pay claims if the contractor finds evidence that using data from the latest settled cost report would not result in the most accurate CCR (42 CFR § 412.84(i)(1)).<sup>6</sup>

A hospital must submit its cost reports, which can include outlier payments, to Medicare contractors within 5 months after the hospital's fiscal year ends. CMS instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report (*Provider Reimbursement Manual*, part 2, § 140). After accepting a cost report,<sup>7</sup> 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.<sup>8</sup> 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 years<sup>9</sup> 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.

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<sup>5</sup> The circumstances discussed in this Federal regulation are also cited in the *Medicare Claims Processing Manual* (Claims Processing Manual), chapter 3, section 20.1.2.2. The Claims Processing Manual further explains that the national geometric mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with 42 CFR § 412.8(b).

<sup>6</sup> CMS may, on its own initiative, direct contractors to use an alternative CCR for the same reason. Claims Processing Manual, chapter 3, section 20.1.2.1(B).

<sup>7</sup> 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.

<sup>8</sup> 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.

<sup>9</sup> Cost reports may be reopened by Medicare contractors beyond 3 years for fraud or similar fault (42 CFR § 405.1885(b)(3); *Provider Reimbursement Manual*, part 1, § 2931.1 (F)).

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

## **CMS Changes in the Hospital Outlier Payment Reconciliation Methodology**

### *Outlier Payment Reconciliation*

CMS developed new outlier regulations<sup>10</sup> and guidance in 2003 after reporting that, from Federal fiscal years 1998 through 2002, it paid approximately \$9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.<sup>11, 12</sup> 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 enable Medicare contractors to settle cost reports.<sup>13</sup>

### *Reconciliation Process*

After the end of the cost-reporting period, the hospital compiles the cost report from which the actual CCR for that cost-reporting period can be computed. The actual CCR may be different than 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<sup>14</sup> is found to be plus or minus 10 percentage points of the CCR used during that period to calculate outlier payments, CMS policy requires the Medicare contractor to refer the hospital's cost report to CMS for reconciliation (Claims Processing Manual, chapter 3, § 20.1.2.5). For this report, we refer to the process of determining whether a cost report qualifies for referral as the "reconciliation test."

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<sup>10</sup> 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).

<sup>11</sup> CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003).

<sup>12</sup> 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.

<sup>13</sup> 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.

<sup>14</sup> Under the provisions of 42 CFR § 412.84(i)(4) and according to our discussions with CMS officials, statewide average or alternative CCRs should not be used in place of the actual CCRs calculated from cost report data.

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

CMS Transmittal 707<sup>15</sup> 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,<sup>16</sup> 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 reconciliation<sup>17</sup> 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 fiscal years 2006 and 2007 SSI ratios in the calculation of disproportionate share hospital (DSH) payments. CMS subsequently expanded the “DSH/SSI hold” to include cost reports using the fiscal years 2008 and 2009 SSI ratios. The DSH/SSI hold remained in effect until CMS published the updated SSI ratios in June 2012.

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<sup>15</sup> CMS, “IPPS Outlier Reconciliation,” Claims Processing Manual, Pub. No. 100-04, Transmittal 707 (Change Request 3966; October 12, 2005).

<sup>16</sup> 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).

<sup>17</sup> CMS uses the term “flagged” to refer to outlier payments whose reconciliations were backlogged between 2005 and April 1, 2011.

## HOW WE CONDUCTED THIS REVIEW

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

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

Appendix B contains details of our audit scope and methodology.

## FINDINGS

Of 72 cost reports with outlier payments that qualified for reconciliation, 45 cost reports had unreliable CCRs because their cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed; we discuss these 45 cost reports below. Of the 27 remaining cost reports with outlier payments that qualified for reconciliation, Palmetto referred 22 cost reports to CMS in accordance with Federal guidelines. However, Palmetto did not refer five cost reports that should have been referred to CMS for reconciliation. Of these, one cost report had not been settled and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with this one cost report and (2) the recalculated outlier payments totaled at least \$2,978,002. We refer to this difference as financial impact.<sup>18</sup> The four remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation; the financial impact of the outlier payments associated with those four cost reports totaled \$7,279,329.

Of the 22 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Palmetto had reconciled the outlier payments associated with 6 cost reports by December 31, 2011. However, Palmetto had not reconciled the outlier payments associated with the remaining 16 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 15 of the 16 cost reports that were referred but not reconciled was at least \$49,534,505. We also calculated that \$4,038,751 was due from Medicare to a provider for 1 of the 16 cost reports that were referred but not reconciled. The net financial

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<sup>18</sup> 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.

impact of the outlier payments associated with these 16 cost reports that were referred but not reconciled was therefore at least \$45,495,754 that was due to Medicare.

Because certain providers require specialized recalculations for their outlier payments, we were unable to recalculate 133 of the 592 claims associated with the cost reports that we were recalculating and are setting aside \$1,142,434 in outlier payments associated with those claims for resolution by Noridian and CMS.<sup>19</sup>

Of the 45 cost reports that qualified for reconciliation and that had unreliable CCRs:<sup>20</sup>

- Palmetto did not refer 28 cost reports that should have been referred to CMS for reconciliation. Of these unreferred cost reports, 11 had not been settled, whereas 17 had been settled and had exceeded the 3-year reopening limit. These 28 cost reports included 24,437 claims and \$34,897,819 in associated outlier payments.
- Palmetto referred the other 17 cost reports that had unreliable CCRs to CMS in accordance with Federal guidelines, but it had not reconciled the outlier payments associated with any of these cost reports by December 31, 2011. These 17 cost reports included 9,555 claims and \$15,792,301 in associated outlier payments.

Because CMS had not resolved the issues related to the reconciliation of cost reports with unreliable CCRs, we were unable to calculate the financial impact for these cost reports and are setting aside the associated 33,992 claims (24,437 + 9,555) and \$50,690,120 in outlier payments (\$34,897,819 + \$15,792,301) for resolution by Noridian and CMS.

See Appendix C for a summary of the status of the 27 cost reports with respect to referral and reconciliation, as well as the associated dollar amounts due to Medicare or to the provider. See Appendix D for a summary of the status of the 45 cost reports with unreliable CCRs with respect to referral and reconciliation, as well as information on the number of claims and the associated outlier payments that we are setting aside.

## **FEDERAL REQUIREMENTS**

Federal regulations state that for discharges occurring on or after October 1, 2003, the CCR applied at the time a claim is processed (and outlier payments are made) is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost-reporting period (42 CFR § 412.84(i)(2)).

If a hospital's total outlier payments during the cost-reporting period exceed \$500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during that period

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<sup>19</sup> This amount is separate from the financial impact amounts mentioned in the two immediately preceding paragraphs.

<sup>20</sup> These cost reports qualified for reconciliation using CCRs that were unreliable. Later in this report, we set aside the outlier claims in those reports and the associated payments for resolution by Noridian and CMS.

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 72 cost reports with outlier payments that qualified for reconciliation, 45 cost reports had unreliable CCRs and are discussed further below. Of the 27 remaining cost reports with outlier payments that qualified for reconciliation, Palmetto referred 22 cost reports to CMS in accordance with Federal guidelines. However, Palmetto did not refer five cost reports that should have been referred to CMS for reconciliation.

### **Cost Reports Within the 3-Year Reopening Limit**

Of the five cost reports that Palmetto did not refer to CMS for reconciliation, one cost report had not been settled and should have been referred to CMS for reconciliation. Because Palmetto 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.<sup>21</sup> We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with this unrefereed cost report totaled at least \$2,978,002 that was due to Medicare.

### **Cost Reports Outside the 3-Year Reopening Limit**

Of the five cost reports that Palmetto did not refer to CMS for reconciliation, the remaining four cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. Palmetto did not refer the four cost reports to CMS because Palmetto 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;

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<sup>21</sup> This cost report was also on hold because of the SSI-related litigation discussed in "Background."

and, if necessary, were reopened before the 3-year reopening limit. As a result of the inadequacy of these control procedures:

- Palmetto did not perform the reconciliation test to identify and refer three cost reports that qualified for reconciliation, and
- Palmetto did not correctly perform the reconciliation test for one cost report and incorrectly concluded that that cost report did not meet the criteria for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these four cost reports totaled at least \$7,279,329 that may be due to Medicare.

### **COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED**

Of the 22 referred cost reports whose outlier payments qualified for reconciliation, Palmetto reconciled the outlier payments associated with 6 cost reports by December 31, 2011. However, Palmetto did not reconcile the outlier payments associated with 16 cost reports by December 31, 2011. The statuses of the cost reports with unreconciled outlier payments were as follows:

- 14 cost reports were on hold because CMS had not calculated revised SSI ratios,
- 1 cost report was on hold because it was awaiting CMS resolution of certain issues, and
- 1 cost report had been correctly referred and approved for outlier reconciliation by CMS but was still being processed before final settlement because the outlier payments had not yet been reconciled.

For the one cost report that had received CMS approval and was undergoing the reconciliation process, Palmetto's policies and procedures did not ensure that it reconciled all outlier payments associated with this referred cost report that qualified for reconciliation in accordance with Federal guidelines. For the other 15 cost reports that were referred but whose outlier payments had not been reconciled, CMS bore principal responsibility for the delays that we have described above.<sup>22</sup>

For the 16 referred cost reports whose outlier payments Palmetto did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least \$49,534,505 that was due to Medicare (15 cost reports) and \$4,038,751 that was due to a provider (1 cost report).<sup>23</sup>

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<sup>22</sup> We will report separately to CMS on issues related to cost report referral and outlier payment reconciliation in a future review.

<sup>23</sup> As stated in "Findings," the net financial impact of the outlier payments associated with these 16 cost reports that were referred but not reconciled was at least \$45,495,754 that was due to Medicare.

## **CLAIMS THAT COULD NOT BE RECALCULATED**

The 16 referred cost reports with unreconciled outlier payments included 133 claims with \$1,142,434 in associated outlier payments. We were unable to recalculate these claims for certain providers (that is, rehabilitation providers) because they required specialized recalculations for their outlier payments. We are therefore setting aside the \$1,142,434 for resolution by Noridian and CMS. We are separately providing to Noridian detailed data on the claims that we could not recalculate.

## **COST REPORTS WITH UNRELIABLE COST-TO-CHARGE RATIOS**

Of the 72 cost reports with outlier payments that qualified for reconciliation, 45 cost reports had unreliable CCRs because their cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed.

The Claims Processing Manual requires Medicare contractors to use specific lines from the cost report data to calculate the actual CCRs that are, in turn, used to determine whether a cost report qualifies for reconciliation (chapter 3, § 20.1.2.1).<sup>24</sup> Some hospitals, though, do not use a formal charge structure and may, instead, bill a flat fee for services or decide not to charge certain beneficiaries at all. For this reason, the actual CCRs that Medicare contractors computed using such hospitals' cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed. In addition, for some cost reports (and during several cost-reporting periods), the actual CCRs computed using cost report data were significantly and consistently higher than the CCRs that were used to pay claims. Although Medicare contractors may use statewide average and CMS-approved alternative CCRs to pay claims during the cost-reporting period in situations when the cost report's actual CCRs may be unreliable, CMS instructions require that the actual CCR be used to determine whether a cost report qualifies for reconciliation. We identified 45 cost reports as having unreliable CCRs.

### **Cost Reports With Unreliable Cost-to-Charge Ratios That Were Not Referred**

Of the 45 cost reports that qualified for reconciliation and that had unreliable CCRs, Palmetto referred 17 cost reports to CMS in accordance with Federal guidelines. However, Palmetto did not refer 28 cost reports that should have been referred to CMS for reconciliation.

Of the 28 unreferred cost reports, 11 had not been settled, but 17 had been settled and had exceeded the 3-year reopening limit. Palmetto did not refer the 28 cost reports because Palmetto had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified; were referred to CMS; and, if necessary, were reopened before the 3-year reopening limit. As a result of the inadequacy of these control procedures:

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<sup>24</sup> As stated in "Background," because a hospital's actual CCR for any given cost-reporting period cannot be known until final settlement of the cost report for that year, the Medicare contractors calculate and make outlier payments using the most current information available when processing a claim.

- Palmetto did not perform the reconciliation test to identify and refer 14 cost reports that qualified for reconciliation,<sup>25</sup> and
- Palmetto did not correctly perform the reconciliation test for 14 other cost reports and incorrectly concluded that those cost reports did not meet the criteria for reconciliation.<sup>26</sup>

Because CMS had not resolved the issues related to the reconciliation of cost reports with unreliable CCRs (it had not, for instance, provided instructions on recalculating the outlier payments associated with cost reports that did not use a formal charge structure or whose outlier payments were paid using statewide average or CMS-approved alternative CCRs), we were unable to calculate the financial impact for these cost reports and are setting aside the 24,437 claims and \$34,897,819 in associated outlier payments for resolution by Noridian and CMS.

### **Cost Reports With Unreliable Cost-to-Charge Ratios That Were Referred but Outlier Payments Not Reconciled**

Of the 17 cost reports with unreliable CCRs that were referred to CMS and that qualified for reconciliation, Palmetto had not reconciled the outlier payments associated with any of these cost reports by December 31, 2011. Palmetto did not reconcile these cost reports because CMS had not resolved the issues related to the reconciliation of cost reports with unreliable CCRs. The statuses of these cost reports with unreconciled outlier payments were as follows:

- 15 cost reports were on hold because they were awaiting CMS resolution of certain issues, and
- 2 cost reports had been correctly referred but were still being processed before final settlement and were still awaiting CMS approval to reconcile the outlier payments.

For these 17 cost reports that were referred but whose outlier payments had not been reconciled, CMS bore principal responsibility for the delays that we have described above.<sup>27</sup>

Because CMS had not resolved the issues related to the reconciliation of cost reports with unreliable CCRs, we were unable to calculate the financial impact for these cost reports and are setting aside the associated 9,555 claims and \$15,792,301 in outlier payments for resolution by Noridian and CMS.

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<sup>25</sup> Eight of these cost reports were also on hold because of the SSI-related litigation, and three other cost reports had exceeded the 3-year reopening limit; both of these factors are discussed in “Background.”

<sup>26</sup> These 14 cost reports had exceeded the 3-year reopening limit discussed in “Background.”

<sup>27</sup> We will report separately to CMS on issues related to cost report referral and outlier payment reconciliation in a future review.

## **Summary of Claims and Outlier Payments Being Set Aside for Cost Reports With Unreliable Cost-to-Charge Ratios**

The combined financial impact of the 45 cost reports with unreliable CCRs included both the 28 cost reports that should have been referred to CMS for reconciliation but were not and the 17 cost reports that were referred to CMS and that qualified for reconciliation but whose outlier payments had not been reconciled. We are therefore setting aside 33,992 claims (24,437 + 9,555) and \$50,690,120 in outlier payments (\$34,897,819 + \$15,792,301) that are associated with these 45 cost reports for resolution by Noridian and CMS.

### **FINANCIAL IMPACT TO MEDICARE**

As of December 31, 2011, the financial impact of the outlier payments associated with the one cost report that was within the 3-year reopening limit was at least \$2,978,002 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 four 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 \$7,279,329 that may be due to Medicare.

For the 16 referred cost reports whose outlier payments Palmetto did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least \$49,534,505 that was due to Medicare (15 cost reports) and \$4,038,751 that was due to a provider (1 cost report). Therefore, the net financial impact to Medicare of the 16 cost reports with unreconciled outlier payments was at least \$45,495,754.

The financial impact summarized here does not take into account the amounts that we are setting aside for resolution by Noridian and CMS (that is, the amounts associated with the 133 claims that we were unable to recalculate as well as the amounts associated with the 45 cost reports with unreliable CCRs).

### **RECOMMENDATIONS**

We recommend that Noridian:

- review the 1 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 \$2,978,002 in funds and associated interest from health care providers, and refund that amount to the Federal Government;
- review the 4 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 \$7,279,329 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the 16 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
  - reconcile the \$49,534,505 in associated outlier payments due to the Federal Government (15 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare, and
  - reconcile the \$4,038,751 in associated outlier payments due from Medicare to a provider (1 cost report), finalize that cost report, and return the funds to the provider;
- work with CMS to resolve the \$1,142,434 in outlier payments associated with the 133 claims that we could not recalculate;
- review the 28 cost reports with unreliable CCRs that should have been referred to CMS for reconciliation but were not, take appropriate actions to refer the 11 cost reports that had not been settled, determine whether the other 17 cost reports that had exceeded the 3-year reopening limit may be reopened, and work with CMS to resolve the \$34,897,819 in outlier payments associated with these 28 cost reports that we could not recalculate;
- review the 17 cost reports with unreliable CCRs that were referred to CMS and had outlier payments that qualified for reconciliation, and work with CMS to resolve the \$15,792,301 in outlier payments associated with these cost reports that we could not recalculate;
- ensure that control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;
- ensure that policies and procedures are in place so that 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, Noridian concurred with our first recommendation and with the findings associated with our third recommendation (the 16 referred cost reports whose outlier payments qualified for reconciliation) and our sixth recommendation (the 17 referred cost reports with unreliable CCRs whose outlier payments qualified for reconciliation). Noridian also described corrective actions that it had taken or planned to take with respect to these three recommendations.

Noridian did not specifically agree or disagree with our fourth recommendation but said that it would work with CMS to resolve the \$1,142,434 in outlier payments associated with the 133 claims that we could not recalculate. Noridian also did not specifically agree or disagree with our last three recommendations, which are procedural. Noridian said that it had procedures in place for reconciliation of outlier payments and, with respect to our final recommendation, said that it would review all cost reports (submitted since the end of our audit period) within the 3-year reopening limit and reopen them “as resources allow.”

Noridian partially concurred with our second recommendation regarding the four cost reports that had exceeded the 3-year reopening limit and should have been referred to CMS but were not. Noridian stated that it had determined that one of the four cost reports should have been referred to CMS. Noridian also said that it was not aware of any regulation that would allow it to reopen these four cost reports but added that it would discuss this issue with CMS.

Noridian made the same comment with respect to the 17 unreferred cost reports (of the 28 unreferred cost reports with unreliable CCRs that form the basis of our fifth recommendation) that had exceeded the 3-year reopening limit. Noridian added that its own review and calculations of these 17 cost reports had led it to determine that 2 of them met the criteria for reconciliation. With respect to the other 11 unreferred cost reports with unreliable CCRs (of the 28 cost reports that our fifth recommendation addresses), Noridian concurred with our findings regarding—and provided updated information on the referral status of—10 of those 11 cost reports. Noridian said that the previous Medicare contractor referred 5 of the 10 cost reports between September 2012 and March 2013; the other 5 cost reports are either still on hold or still in progress. Noridian added that the previous Medicare contractor had settled the other cost report (of those 11) in March 2013 after using a different method (statewide average CCR) to calculate that cost report’s CCR. According to Noridian, the previous contractor then determined that referral was not required for this cost report.

Noridian’s comments appear in their entirety as Appendix E.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing Noridian’s comments, we maintain that all of our findings and recommendations remain valid.

For the cost reports discussed in our second and fifth recommendations, the information that Noridian provided regarding the referral status of certain cost reports agreed with our own analysis of their status. After receiving Noridian’s comments, we also reevaluated the cost reports discussed in those two recommendations and reverified that those cost reports met the criteria for reconciliation of outlier payments.<sup>28</sup>

Accordingly, for the four cost reports that exceeded the 3-year reopening limit as stated in our second recommendation and the associated finding, we reaffirm that all four cost reports met the criteria for outlier reconciliation.

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<sup>28</sup> See “How We Conducted This Review” and Appendix B.

Regarding all of the cost reports that had exceeded the 3-year reopening limit (both the 4 cost reports in our second recommendation and 17 of the 28 cost reports in our fifth recommendation), CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of “fraud or similar fault.” Specifically, 42 CFR § 405.1885(b)(3) provides that a Medicare payment contractor (e.g., Noridian) 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 determining 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, 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 recommendations and recognize that ultimately, CMS, as the cognizant Federal agency, has the authority to decide how to resolve these and the other recommendations in this audit report. Therefore, we continue to recommend that Noridian determine whether these providers procured Medicare funds by “similar fault” and work with CMS to resolve their unreconciled outlier payments.

With respect to the other 11 unreferred cost reports with unreliable CCRs that our fifth recommendation addresses, Noridian concurred with our finding that 10 of the then-unreferred cost reports should be referred to CMS. Moreover, we continue to recommend that the other cost report (of these 11), which Noridian described as having been settled by the previous Medicare contractor in March 2013, be referred to CMS as well. The circumstances under which a Medicare contractor may use a CCR other than the CCR from the most recent settled cost report or the most recent tentative settled cost report—for instance, a statewide average CCR—are limited (42 CFR §§ 412.84(i)(1) and (3)). Of relevance in this case is that a Medicare contractor may use a statewide average CCR to calculate and pay outlier claims, but must use an actual CCR when performing the reconciliation test for that cost report.<sup>29</sup>

With respect to our final recommendation—that Noridian review all cost reports submitted since the end of our audit period and ensure those whose outlier payment qualified for reconciliation are referred and reconciled in accordance with Federal guidelines—Noridian said that it would do so, as resources allow, for all cost reports within the 3-year reopening limit. We continue to recommend that, in conformance with Federal requirements, Noridian review all cost reports submitted since the end of our audit period, including those that exceed the 3-year reopening limit, and work with CMS to determine whether those cost reports can be reopened under the “fraud or similar fault” provision discussed above.

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<sup>29</sup> See additional discussion in “Hospital Outlier Payments, Medicare Cost Report Submission, and Settlement Process” and the discussion of the reconciliation process in “CMS Changes in the Hospital Outlier Payment Reconciliation Methodology” (to include footnote 14), both appearing earlier in this report.

**APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>CGS Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-13-02791	05/29/15
<i>Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 11</i>	<a href="#">A-07-10-02775</a>	04/23/15
<i>National Heritage Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-05-11-00024</a>	04/21/15
<i>Cahaba Government Benefit Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-05-11-00019</a>	03/30/15
<i>Novitas Solutions, Inc. (Formerly Highmark Medicare Services, Inc.), Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-05-11-00023</a>	03/27/15
<i>First Coast Service Options, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-05-11-00022</a>	03/27/15
<i>National Government Services, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 8</i>	<a href="#">A-05-14-00046</a>	03/16/15
<i>Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-07-10-02774</a>	12/16/14
<i>Wisconsin Physicians Service Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-07-10-02777</a>	11/18/14
<i>Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-07-11-02773</a>	10/29/14
<i>TrailBlazer Health Enterprises Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required</i>	<a href="#">A-07-10-02776</a>	06/10/14
<i>The Centers for Medicare &amp; Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance</i>	<a href="#">A-07-10-02764</a>	06/28/12

## **APPENDIX B: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Palmetto 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.<sup>30</sup> 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 Denver, Colorado, field office from December 2010 to April 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 Palmetto and other Medicare contractors concerning the reconciliation process and the Medicare contractors' responsibilities, including those related to the reconciliation of cost reports with unreliable CCRs;
- obtained from CMS a list of cost reports that Medicare contractors had referred for reconciliation;
- held discussions with Palmetto officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed Palmetto'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 Palmetto's jurisdiction as of December 28, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that Palmetto had referred to CMS for reconciliation during our audit period;

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<sup>30</sup> 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 cost report data from CMS’s database for cost reports with fiscal-year ends during our audit period;
- obtained the Inpatient Acute Care and LTCH provider specific files (PSFs) from the CMS Web site;
- determined which cost reports qualified for reconciliation by:
  - using the information in a CMS database to identify acute-care and long-term-care cost reports that had greater than \$500,000 in outlier payments<sup>31</sup> and
  - using the information in CMS’s database and PSF data to calculate and compare the actual and weighted average CCRs to determine whether the resulting variance was greater than 10 percentage points;
- verified that Palmetto used the three different types of outlier payments specified by Federal regulations<sup>32</sup> (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;
- requested that Palmetto provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;<sup>33</sup>
- reviewed Palmetto’s response and categorized the cost reports according to their respective statuses;
- verified whether Palmetto 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 Palmetto did not recalculate the outlier payments:
  - obtained the detailed Provider Statistical & Reimbursement reports from Palmetto or obtained the National Claims History data from CMS;
  - verified the original outlier payments using the CCR that was used to pay the claim;<sup>34</sup>

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<sup>31</sup> CMS cost report data included operating and capital payments but did not include short-stay outlier payments.

<sup>32</sup> Claims Processing Manual, chapter 3, § 20.1.2.5.

<sup>33</sup> Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by Palmetto.

<sup>34</sup> We set aside claims whose original outlier payments we could not verify.

- recalculated the outlier payment amounts for those cost reports that Palmetto did not recalculate, using the actual CCRs;
  - identified those claims that we were unable to recalculate either because we could not verify the original outlier payment calculation for particular claims, because the claims were for providers that required specialized recalculations, or because some of the CCRs from the CMS database were so anomalous as to be of questionable reliability; and
  - calculated accrued interest<sup>35</sup> 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 Noridian officials on April 15, 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.

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<sup>35</sup> We calculated interest by referring to the Claims Processing Manual, chapter 3, § 20.1.2.6.

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

**Table 1: Total Cost Reports and Amounts Due**

<b>Grand Total</b>	<b>Due to Medicare</b>	<b>Due to Provider</b>
<b>27 Cost Reports</b>	<b>\$66,298,886</b>	<b>\$5,697,646</b>

**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			
<b>Number of Cost Reports</b>	0	0	1	4	5	5
<b>Balance Due to Medicare</b>	0	0	\$2,624,646	\$5,727,668	\$8,352,314	\$8,352,314
<b>Interest Due to Medicare</b>	0	0	353,356	1,551,661	1,905,017	1,905,017
<b>Balance Due to Provider</b>	0	0	0	0	0	0
<b>Interest Due to Provider</b>	0	0	0	0	0	0
<b>Total Due to Medicare</b>	<b>0</b>	<b>0</b>	<b>\$2,978,002</b>	<b>\$7,279,329</b>	<b>\$10,257,331</b>	<b>\$10,257,331</b>
<b>Total Due to Provider</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**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			
<b>Number of Cost Reports</b>	6	1	15	0	16	22
<b>Balance Due to Medicare</b>	\$5,980,253	\$309,666	\$44,946,513	\$0	\$45,256,179	\$51,236,432
<b>Interest Due to Medicare</b>	526,797	42,226	4,236,100	0	4,278,326	4,805,123
<b>Balance Due to Provider</b>	1,492,982	0	3,761,471	0	3,761,471	5,254,453
<b>Interest Due to Provider</b>	165,913	0	277,280	0	277,280	443,193
<b>Total Due to Medicare</b>	<b>\$6,507,050</b>	<b>\$351,892</b>	<b>\$49,182,613</b>	<b>\$0</b>	<b>\$49,534,505</b>	<b>\$56,041,555</b>
<b>Total Due to Provider</b>	<b>\$1,658,895</b>	<b>\$0</b>	<b>\$4,038,751</b>	<b>\$0</b>	<b>\$4,038,751</b>	<b>\$5,697,646</b>

**Note:** The dollar amounts associated with these cost reports do not reflect the 133 claims that we were unable to recalculate.

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

**Table 1: Total Cost Reports With Unreliable Cost-to-Charge Ratios and Amounts Set Aside**

Grand Total	Claims Set Aside	Outlier Payments Set Aside
45 Cost Reports	33,992	\$50,690,120

**Table 2: Cost Reports With Unreliable Cost-to-Charge Ratios That Were Not Referred (OIG Identified)**

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		Past 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
Number of Cost Reports	0	0	11	17	28	28
Number of Claims Being Set Aside	0	0	14,078	10,359	24,437	24,437
Outlier Payments Being Set Aside	\$0	\$0	\$16,165,163	\$18,732,656	\$34,897,819	\$34,897,819

**Table 3: Cost Reports With Unreliable Cost-to-Charge Ratios That Were 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	0	2	15	0	17	17
Number of Claims Being Set Aside	0	387	9,168	0	9,555	9,555
Outlier Payments Being Set Aside	\$0	\$5,224,670	\$10,567,631	\$0	\$15,792,301	\$15,792,301

## APPENDIX E: AUDITEE COMMENTS



900 42nd Street South  
Fargo, ND 58103

February 23, 2015

Patrick J. Cogley, Regional Inspector General  
Office of Inspector General – Office of Audit Services  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

Dear Mr. Cogley:

Noridian Healthcare Solutions, LLC (Noridian) has reviewed the draft report, A-07-13-02795, entitled *Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 1*. As noted in the report, responsibilities for the work reviewed in this audit transitioned to Noridian in August 2013. Below are our comments and responses to the OIG's recommendations.

**OIG Recommendation:** Review the 1 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 \$2,978,002 in funds and associated interest from health care providers, and refund that amount to the Federal Government.

**Noridian Response:** We concur and have determined that the previous contractor referred this cost report to CMS on February 22, 2013. We have not received instructions from CMS to reconcile the outliers on this cost report. We will inquire with CMS regarding the status of this referral.

**OIG Recommendation:** Review the 4 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 \$7,279,329 in funds and associated interest from health care providers that may be due to the Federal Government.

**Noridian Response:** Noridian partially concurs with this recommendation. We have reviewed the four cost reports in this category. The previous contractor completed the calculations to determine if the cost reports needed to be referred for outlier reconciliation. In each of these cases, the determination was made that the cost reports did not need to be referred for outlier reconciliation. As a result, the cost reports were settled with no referral to CMS. We are not certain how OIG's calculations differ from

A CMS Medicare Administrative Contractor

Noridian Healthcare Solutions, LLC



29312033 (3203) 4-13

the previous contractor's calculations; however, we have determined that one of the four cost reports should have been referred to CMS. The NPRs were issued more than three years ago and we are not aware of any regulation that would allow us to reopen the cost reports. Noridian will discuss reopening these cost reports with CMS to determine if they have further instructions.

**OIG Recommendation:** Review the 16 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:

- Reconcile the \$49,534,505 in associated outlier payments due to the Federal Government (15 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare.
- Reconcile the \$4,038,751 in associated outlier payments due from Medicare to a provider (1 cost report), finalize that cost report, and return the funds to the provider.

**Noridian Response:** We concur that these cost reports were referred to CMS and qualify for reconciliation. The previous contractor reconciled three of the 16 cost reports and the NPRs were issued in 2013. We will work with CMS to obtain approval to reconcile the outlier amounts and finalize the other 13 cost reports.

**OIG Recommendation:** Work with CMS to resolve the \$1,142,434 in outlier payments associated with the 133 claims that we could not recalculate.

**Noridian Response:** We will work with CMS to try to resolve the \$1,142,434 in outlier payments.

**OIG Recommendation:** Review the 28 cost reports with unreliable CCRs that should have been referred to CMS for reconciliation but were not, take appropriate actions to refer the 11 cost reports that had not been settled, determine whether the other 17 cost reports that had exceeded the 3-year reopening limit can be reopened, and work with CMS to resolve the \$34,897,819 in outlier payments associated with these 28 cost reports that we could not recalculate.

**Noridian Response:** We concur that 10 of the 11 cost reports that had not been settled should be referred to CMS, if the calculations require referral. The previous contractors referred five of the 10 cost reports between September 2012 and March 2013 because these cost report years are no longer on DSH hold. Four of the 10 are still on DSH hold and the calculations, which have recently been completed by Noridian show that they should be referred. We are referring these cost reports to CMS. One of the 10 is pending audit, so we cannot yet determine if referral is warranted. The previous contractor did not complete the referral of these 10 cost reports because the cost reports were on hold pending issuance of revised SSI ratios by CMS. One of the 11 cost reports was settled in March 2013 and it was not referred for outlier reconciliation. The previous Contractor used the statewide average to

determine if the provider should be referred instead of using the provider's unreliable CCR, which was based on relative value units (RVUs) instead of charges. As a result, they made the determination that referral was not required.

We reviewed the work papers for the 17 cost reports categorized with high CCRs that were not referred to CMS. Based on the previous Contractor's calculations, it was determined that these cost reports did not meet the threshold for referral. We are not certain how OIG's calculations differ from the previous contractor's calculations; however, we have determined that two of the 17 cost reports did meet the threshold for referral after we updated the outlier amount to include capital outliers.

The NPRs for these 17 cost reports were issued more than three years ago and we are not aware of any regulation that would allow us to reopen the cost reports. Noridian will discuss reopening these cost reports with CMS.

**OIG Recommendation:** Review the 17 cost reports with unreliable CCRs that were referred to CMS and had outlier payments that qualified for reconciliation, and work with CMS to resolve the \$15,792,301 in outlier payments associated with these cost reports that we could not recalculate.

**Noridian Response:** We concur that these cost reports were referred to CMS and qualify for reconciliation. We will work with CMS to obtain approval to reconcile the outlier amounts and issue the NPR for these cost reports. Fourteen of these reports are for fiscal years FY2005 and prior, which are still awaiting CMS' issuance of revised SSI ratios. NPRs cannot be issued until the revised SSI ratios are published.

**OIG Recommendation:** 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.

**Noridian Response:** Noridian has procedures in place that require outlier reconciliations for all applicable cost reports before final settlement. These procedures also address the need to reopen cost reports that have already been settled.

**OIG Recommendation:** 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.

**Noridian Response:** Noridian has procedures in place to reconcile outlier payments for providers approved by CMS.

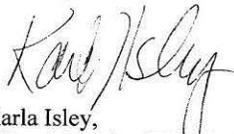
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**OIG Recommendation:** Review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

**Noridian Response:** Noridian will review all cost reports that fall within the three-year rule for reopening as resources allow. As part of our regular desk review process, Noridian reviews to determine whether the criteria for outlier reconciliation are met. Those that meet the outlier reconciliation are referred and reconciled in accordance with Federal guidelines.

We appreciate the opportunity to comment on this report and the findings. If you have any questions on this response and Noridian's actions, please contact me at 701-277-6777.

Sincerely,



Karla Isley,  
VP and Interim JE Project Manager

cc: Pamela Bragg, JE COR, CMS  
Tom McGraw, CEO, and President of Noridian Healthcare Solutions, LLC