

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**VULNERABILITIES REMAIN  
IN MEDICARE HOSPITAL  
OUTLIER PAYMENTS**

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# *Office of Inspector General*

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## Report in Brief

Date: September 2017  
Report No. A-07-14-02800

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Review

The Centers for Medicare & Medicaid Services (CMS) relies on Medicare contractors to reconcile outlier payments, which compensate hospitals for high-cost cases. These reconciliations ensure that outlier payments reflect hospitals' actual costs.

In a series of previous audits, we reported that Medicare contractors had not always referred hospital cost reports that qualified for reconciliation and had not always reconciled the associated outlier payments. This review summarizes the findings from that series of reviews.

Our objective was to summarize the results of our individual Medicare contractor reviews of cost report referrals and reconciliation of outlier payments.

### How OIG Did This Review

We summarized the results of our previous reviews of the Medicare contractors and, where appropriate, updated the status of the cost reports identified during those reviews.

Our previous reviews focused on determining whether Medicare contractors had referred cost reports to CMS for reconciliation in accordance with Federal guidelines and whether the outlier payments associated with qualifying cost reports had been reconciled.

## Vulnerabilities Remain in Medicare Hospital Outlier Payments

### What OIG Found

The summarized results of our individual Medicare contractor reviews revealed that for the period October 2003 through March 2011, Medicare contractors did not always refer cost reports that qualified for reconciliation, and CMS did not always ensure that Medicare contractors reconciled the outlier payments associated with cost reports that had been referred.

Our previous reviews identified 465 cost reports that qualified for reconciliation of outlier payments. As of December 31, 2011, 110 of these 465 cost reports had not been referred for reconciliation. As of the same date, 287 cost reports had been referred, but of these, 153 cost reports had not had their outlier payments reconciled. The remaining 68 cost reports qualified for reconciliation but may have had inaccurate cost report data. Audit resolution measures taken by CMS and the Medicare contractors after issuance of our previous reviews resulted in the referral of a number of the formerly unrefereed cost reports, and reconciliation of some of the outlier payments, that we had identified in those previous reviews. However, according to CMS and as of November 15, 2016, there were 211 cost reports that remained under review and were pending completion of the reconciliation process.

CMS did not maintain a complete listing of the cost reports that Medicare contractors had referred for reconciliation. Moreover, CMS did not always ensure that the contractors correctly identified cost reports that qualified for reconciliation, referred all qualifying cost reports to CMS for reconciliation, and reconciled the associated outlier payments.

### What OIG Recommends and CMS Comments

We made recommendations to CMS regarding the continuation of corrective actions by the Medicare contractors, the reopening of cost reports, the review of cost reports submitted since the end of our previous audit periods, and the maintenance of a system that identifies and tracks referred cost reports and that recalculates outlier payments.

CMS concurred with two of our recommendations and described corrective actions that it had taken. CMS also described corrective actions that it had taken or planned to take that were in keeping with our other two recommendations.

## TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Review .....	1
Objective .....	1
Background .....	2
Medicare and Outlier Payments .....	2
Consolidation of the Medicare Contractors .....	2
Hospital Outlier Payments, Medicare Cost Report Submission, and Cost Report Settlement Process .....	3
CMS Changes in the Hospital Outlier Payment Reconciliation Methodology .....	4
CMS Lump Sum Utility Used in Outlier Recalculation .....	6
Cost Reports Held for Settlement.....	6
How We Conducted This Review .....	7
FINDINGS.....	7
Federal Requirements.....	9
Summarized Results of Individual Medicare Contractor Reviews of Cost Report Referral and Reconciliation of Outlier Payments.....	9
Cost Reports That Qualified for Outlier Payments but Were Not Referred to CMS for Reconciliation .....	10
Cost Reports That Qualified for Outlier Payments and That Were Referred to CMS but Whose Associated Outlier Payments Were Not Reconciled .....	12
Cost Reports With Unreliable Cost-to-Charge Ratios and Whose Outlier Payments Qualified for Reconciliation .....	15
Summary of Outlier Payments Associated With Claims That We Were Unable to Recalculate .....	17
System Needed To Identify and Track Referred Cost Reports and To Recalculate Outlier Payments .....	17
Summary of Financial Impact to Medicare.....	18
Financial Impact of Unreferred Cost Reports .....	18
Financial Impact of Referred Cost Reports With Outlier Payments That Were Not Reconciled .....	18

Updated Status of Medicare Cost Report Referral and Reconciliation of Outlier Payments .....	19
RECOMMENDATIONS .....	19
CMS COMMENTS .....	20
APPENDIXES	
A: Related Office of Inspector General Reports .....	21
B: Audit Scope and Methodology .....	23
C: Federal Requirements and Guidance .....	26
D: Summary of Amounts Due to Medicare or Hospitals by Cost Report Category .....	27
E: Summary of Amounts Set Aside for Cost Reports With Unreliable Cost-to-Charge Ratios by Cost Report Category .....	29
F: CMS Comments .....	30

## INTRODUCTION

### WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) implemented new inpatient outlier regulations and guidance in calendar year (CY) 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 Medicare-participating hospital (hospital) had incurred. CMS policy states that if the ratio of costs to charges and the outlier payments reflected in a hospital's cost report meets specified criteria for reconciliation (referred to as "reconciliation thresholds"), the Medicare contractor should refer the cost report to CMS for reconciliation of outlier payments (reconciliation).<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 and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. This report summarizes the findings from that series of reviews.

### OBJECTIVE

Our objective was to summarize the results of our individual Medicare contractor reviews of cost report referrals and reconciliation of outlier payments.

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<sup>1</sup> Although CMS did not instruct Medicare contractors to refer hospitals in need of reconciliation until CY 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; Jul. 3, 2003) instructed Medicare contractors to perform reconciliations. Later, CMS Transmittal 707 (Change Request 3966; Oct. 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 Jun. 28, 2012.

## **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 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 CY 2003, Medicare contractors were to refer hospitals' cost reports to CMS (cost report referral) for reconciliation of outlier payments 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.

The previous reviews listed in Appendix A focused on one of the CY 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.

### **Consolidation of the Medicare Contractors**

When CMS initiated Medicare contracting reform in CY 2003, it established 15 regional Parts A and B Medicare contractor jurisdictions to serve the Nation. Starting in CY 2010, CMS began consolidating the 15 Parts A and B Medicare contractor jurisdictions into 10 jurisdictions. As of March 2014 (when CMS announced that it was postponing the remaining consolidations for 5 years),<sup>3</sup> CMS had completed 3 of these consolidations, with 12 contract workloads remaining to be consolidated. This ongoing initiative meant that some cost reports were transitioning between Medicare contractors, both during our previous reviews and during our preparation of this rollup report.

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<sup>3</sup> CMS announced this decision in a Request for Information, *Postponement of Final Two [Medicare Parts] A/B MAC [Medicare Administrative Contractor] Contract Consolidations*, Mar. 19, 2014. See [https://www.fbo.gov/index?s=opportunity&mode=form&id=97379d7710bcfb0222cb6fdc465c540e&tab=core&\\_cview=0](https://www.fbo.gov/index?s=opportunity&mode=form&id=97379d7710bcfb0222cb6fdc465c540e&tab=core&_cview=0) (accessed Mar. 30, 2016).

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

To qualify for outlier payments, a claim must have costs that exceed a CMS-established fixed-loss 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)). 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 (CMS's *Provider Reimbursement Manual*, part 2, § 140). After accepting a cost report,<sup>4</sup> the Medicare contractor completes its preliminary review and may issue a tentative settlement to the hospital.<sup>5</sup>

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 called the Healthcare Cost Report Information System (HCRIS).

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 and finalizes Medicare reimbursements due from or to the hospital.<sup>6</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.

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<sup>4</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>5</sup> 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.

<sup>6</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.

In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years<sup>7</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.

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 our series of reviews of individual Medicare contractors, 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**

CMS established the reconciliation process to address two vulnerabilities in the outlier payment reconciliation mechanism:

- The first vulnerability was the timelag between the submission of current charges on a claim and calculation of the CCR taken from the most recent settled cost report. This timelag permitted some hospitals that inflated their charges to receive excessive outlier payments because those payments were processed with outdated CCRs.
- The second vulnerability was that some hospitals had increased their billed charges so far above costs that outlier payments were not always limited to unusually high-cost cases.

CMS and OIG have previously determined that some hospitals have dramatically increased charges in an effort to inappropriately maximize outlier reimbursement.<sup>8</sup> The Final Rule was intended to address these vulnerabilities as explained below.

#### *Use of Updated Cost-to-Charge Ratios*

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

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<sup>7</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)).

<sup>8</sup> See (1) 68 Fed. Reg. 34494, 34495-98 (Jun. 9, 2003) (Final Rule), and (2) OIG, *Audit of the Effectiveness of the Revised Medicare Outlier Payment Regulations for Inpatient Acute Care Hospitals* (A-07-04-04032), Sept. 9, 2005. In the Preamble to the Final Rule, CMS reported that from Federal FYs 1998 through 2002, it paid approximately \$9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.

### *Outlier Payment Reconciliation*

To address the second vulnerability, the Final Rule and CMS guidance both say that outlier payments may be reconciled upon cost report settlement to account for the differences between the CCR used to pay the claim and the final CCR for the reporting period during which the discharge occurred (42 CFR § 412.84(i)(4) and CMS's *Medicare Claims Processing Manual* (Claims Processing Manual), chap. 3, § 20.1.2.5).

CMS Transmittal 707 provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations.<sup>9</sup> The new requirements were intended to ensure that when final outlier payments were made, they would accurately reflect the actual costs the hospital incurred. Medicare contractors were to refer hospitals' cost reports to CMS (through the process previously identified as "cost report referral") for reconciliation of outlier payments so it could correctly reprice submitted claims and allow Medicare contractors to settle cost reports. (See footnote 1 earlier in this report.)

### *Use of Reconciliation Thresholds To Identify Outlier Payments That Qualify for Reconciliation*

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 payments during the cost-reporting period.

Under the reconciliation mechanism that CMS established, once a Medicare contractor has computed the actual CCR, the outlier payments associated with that cost report are subject to reconciliation if (as specified in the Claims Processing Manual) those payments meet these reconciliation thresholds:

- the actual CCR is found to be plus or minus 10 percentage points from the estimated CCR used during that time period to calculate outlier payments and
- total outlier payments in that cost-reporting period exceed \$500,000.

If the Medicare contractor determines that the outlier payments in a hospital's cost report meet these reconciliation thresholds, CMS policy requires the Medicare contractor to refer the cost report to CMS for reconciliation (Claims Processing Manual, chap. 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>9</sup> CMS, "IPPS Outlier Reconciliation," Claims Processing Manual, CMS Transmittal 707 (Change Request 3966; Oct. 12, 2005).

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) for reconciliation.

The assignment of CMS to perform reconciliations (CMS Transmittal 707) remained in effect until April 1, 2011. In CMS Transmittal 2111,<sup>10</sup> CMS directed the Medicare contractors to assume the responsibility to perform backlogged reconciliations, effective April 1, 2011, as well as all future reconciliations. CMS Transmittal 2111 also said that Medicare contractors should perform reconciliations only if they receive prior approval from CMS. In that document, CMS also stated 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>11</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 payments 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 Held for Settlement**

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.

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<sup>10</sup> 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, CMS Transmittal 2111 (Change Request 7192; Dec. 3, 2010).

<sup>11</sup> CMS uses the term “flagged” to refer to outlier payments whose reconciliations were backlogged between CY 2005 and April 1, 2011.

## HOW WE CONDUCTED THIS REVIEW

To address our objective, we summarized the results of our previous 13 reviews of individual Medicare contractors (Appendix A) and, where appropriate, updated the status of cost reports identified during our previous reviews. When conducting those reviews, we compared records from the HCRIS database to information received from the Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008. We did so to determine whether Medicare contractors 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>12</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, where necessary, recalculated the outlier payments and determined the amounts due (including associated interest) to Medicare or to hospitals.

We conducted this performance audit in accordance with generally accepted government auditing standards.<sup>13</sup> 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

The summarized results of our individual Medicare contractor reviews (Appendix A) revealed that from October 1, 2003, through March 31, 2011, and contrary to Federal regulations and guidance, Medicare contractors did not always refer cost reports that qualified for reconciliation, and CMS did not always ensure that Medicare contractors reconciled the outlier payments associated with cost reports that had been referred for reconciliation. In our previous series of reviews, we identified 465 cost reports that, as of December 31, 2011, qualified under CMS regulations and policy for reconciliation of outlier payments. As is summarized in Table 1 on the following page:

- One hundred ten of the 465 cost reports had not been referred for reconciliation as of December 31, 2011. We calculated, in those previous reviews, that the financial impact of the 110 unrefereed cost reports totaled \$155,826,145 in funds due to Medicare and \$11,509,084 in funds due to hospitals.

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<sup>12</sup> Although the CMS-established deadline for reconciling the cost reports was October 1, 2011, for the individual Medicare contractor reviews we provided a 3-month grace period by establishing December 31, 2011, as our cutoff date.

<sup>13</sup> All of the previous audits (Appendix A) included in this rollup report were also conducted in accordance with generally accepted government auditing standards.

- Two hundred eighty-seven of the 465 cost reports had been referred as of this same date, and of that number, 134 cost reports had had their outlier payments reconciled but 153 had not. We calculated, in those previous reviews, that the financial impact of the 153 referred cost reports whose outlier payments had not been reconciled totaled \$298,878,787 in funds due to Medicare and \$17,301,432 in funds due to hospitals.
- The remaining 68 cost reports (of the 465) had unreliable CCRs; that is, these 68 cost reports (which had \$144,905,579 in associated outlier payments) qualified for reconciliation but with CCRs that were not reliable because their cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed. Because CMS had not resolved the issues related to the reconciliation of the outlier payments for these 68 cost reports as of the conclusion of our audit work for the previous reviews, we were unable to calculate the financial impact for these cost reports. Consequently, we recommended that the Medicare contractors and CMS resolve the \$144,905,579 in associated outlier payments that had, in our previous reviews, been set aside for their resolution.

**Table 1: Status of Medicare Cost Report Referral and Reconciliation of Outlier Payments as of December 31, 2011**

Cost Report Category	Not Referred				Referred				Unreliable CCRs	Total
	Reconciled	Not Reconciled		Not Referred Subtotal	Reconciled	Not Reconciled		Referred Subtotal		
		Within 3 Years	After 3 Years			Within 3 Years	After 3 Years			
<b>Number of Cost Reports</b>	1	50	59	<b>110</b>	134	148	5	<b>287</b>	68	<b>465</b>

We calculated in our previous reviews that the net financial impact of the unreferred cost reports combined with the unreconciled outlier payments totaled \$425,893,413 in funds due to Medicare.

Of the 110 unreferred cost reports we identified in our previous reviews, 59 had been settled and exceeded the 3-year reopening limit.<sup>14</sup> In addition, of the 153 referred cost reports whose outlier payments should have been reconciled but were not, 5 had been settled and exceeded the 3-year reopening limit.

Our previous reviews also set aside, for resolution by Medicare contractors and CMS, \$10,386,678 in outlier payments associated with an additional 2,975 claims that we were

<sup>14</sup> See our discussion of the 3-year reopening limit in “Hospital Outlier Payments, Medicare Cost Report Submission, and Cost Report Settlement Process” earlier in this report.

unable to recalculate because certain hospitals require specialized recalculations for their outlier payments.

From October 1, 2003, through March 31, 2011, when it had the responsibility to perform reconciliations, CMS did not implement an automated system that would recalculate outlier payments using actual CCRs without adversely affecting other data. In addition, CMS did not maintain a complete listing of the cost reports that Medicare contractors had referred for reconciliation.

CMS was primarily responsible for the delays that prevented the reconciliation of the outlier payments associated with 107 of the 153 referred cost reports described above. For the other 46 cost reports that were referred but whose outlier payments were not reconciled, the delays that prevented the reconciliation of outlier payments were generally attributable to inadequacies in policies and procedures on the parts of the Medicare contractors.

## **FEDERAL REQUIREMENTS**

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, Federal regulations specify that 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)).

CMS's Claims Processing Manual establishes the reconciliation thresholds at which the Medicare contractor is to refer the hospital's cost report to CMS for reconciliation (chap. 3, § 20.1.2.5).

CMS Transmittals 707 and 2111 provided instructions on the reconciliation process and assigned responsibility (first to CMS, then to the Medicare contractors) to perform reconciliations. In CMS Transmittal 2111, CMS also stated that it had not performed reconciliations because of system limitations.

Federal regulations and guidance address the adjustment of outlier payments to account for the time value of money of any underpayments or overpayments, as well as the calculation of the time value of money (42 CFR § 412.84(m) and the Claims Processing Manual, chap. 3, § 20.1.2.6).

Details on these Federal regulations and guidance appear in Appendix C.

## **SUMMARIZED RESULTS OF INDIVIDUAL MEDICARE CONTRACTOR REVIEWS OF COST REPORT REFERRAL AND RECONCILIATION OF OUTLIER PAYMENTS**

The summarized results of our individual Medicare contractor reviews (Appendix A) revealed that from October 1, 2003, through March 31, 2011, and contrary to Federal regulations and

guidance, Medicare contractors did not always refer cost reports that qualified for reconciliation, and CMS did not always ensure that Medicare contractors reconciled the outlier payments associated with cost reports that had been referred for reconciliation.<sup>15</sup>

### **Cost Reports That Qualified for Outlier Payments but Were Not Referred to CMS for Reconciliation**

In our previous series of reviews, we identified 465 cost reports that, as of December 31, 2011, qualified under CMS regulations and policy for reconciliation of outlier payments. Of these, 68 cost reports had unreliable CCRs and are discussed further below. Of the 397 remaining cost reports with outlier payments that qualified for reconciliation, Medicare contractors referred 287 cost reports to CMS in accordance with Federal guidelines. However, Medicare contractors did not refer 110 cost reports that should have been referred to CMS for reconciliation.<sup>16</sup>

We calculated in those previous reviews that the financial impact of the 110 unreferred cost reports totaled \$155,826,145 in funds due to Medicare and \$11,509,084 in funds due to hospitals. As discussed below and in Appendix D, Table 3, some of these 110 cost reports were within the 3-year reopening limit and some were outside that limit; these cost reports also included claims that we were unable to recalculate.

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

Of the 110 cost reports that Medicare contractors should have referred to CMS for reconciliation but did not, a Medicare contractor referred and reconciled the outlier payments associated with 1 cost report after we started our audit of that individual contractor. However, 50 cost reports had not been settled or were settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. The Medicare contractors did not refer the 50 cost reports to CMS because they had not established adequate controls to ensure that they identified all cost reports whose outlier payments qualified for reconciliation.<sup>17</sup> Specifically:

- the Medicare contractors did not perform the reconciliation test to identify and refer 42 cost reports that qualified for reconciliation,

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<sup>15</sup> Since issuance of our previous reviews, CMS has worked with Medicare contractors to resolve some of these issues. See “Updated Status of Medicare Cost Report Referral and Reconciliation of Outlier Payments” later in this report.

<sup>16</sup> We are not including one additional cost report submitted by a hospital that transitioned to another Medicare contractor and left the Medicare program during the audit period of one of our previous reviews. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with this cost report was at least \$97,568 in funds due to Medicare. We have separately provided detailed data on this cost report to CMS for resolution.

<sup>17</sup> Of these 50 cost reports, 23 were also on hold because of the SSI-related litigation discussed in “Background” and 1 cost report was on hold because of a congressional inquiry.

- the Medicare contractors did not correctly perform the reconciliation test for 2 cost reports and incorrectly concluded that those cost reports did not meet the criteria for reconciliation, and
- the Medicare contractors did not refer 6 cost reports that qualified for reconciliation even though the Medicare contractors correctly performed the reconciliation test and recognized that those cost reports qualified for reconciliation.

We calculated, in those previous reviews, that as of December 31, 2011, the financial impact of the outlier payments associated with these 50 unreferred cost reports totaled at least \$81,917,455 in funds due to Medicare (43 cost reports) and \$7,431,037 in funds due to hospitals (7 cost reports).

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

Of the 110 cost reports that Medicare contractors should have referred to CMS for reconciliation but did not, the remaining 59 cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. The Medicare contractors did not refer 6 of the 59 cost reports because the cost reports had exceeded the 3-year reopening limit by the time those Medicare contractors became responsible for them. The Medicare contractors did not refer the other 53 cost reports to CMS because they had not established adequate controls to ensure that they identified all cost reports whose outlier payments qualified for reconciliation, referred them to CMS and, if necessary, reopened them before the 3-year reopening limit. Specifically:

- the Medicare contractors did not perform the reconciliation test to identify and refer 34 cost reports that qualified for reconciliation,
- the Medicare contractors did not correctly perform the reconciliation test for 14 cost reports and incorrectly concluded that those cost reports did not meet the criteria for reconciliation, and
- the Medicare contractors did not refer 5 cost reports that qualified for reconciliation even though the Medicare contractors correctly performed the reconciliation test and recognized that those cost reports qualified for reconciliation.

We calculated in those previous reviews that as of December 31, 2011, the financial impact of the outlier payments associated with these 59 cost reports totaled at least \$73,508,182 that may be due to Medicare (54 cost reports) and \$4,078,047 that may be due to hospitals (5 cost reports).

Because the outlier reconciliation rules are promulgated in Federal regulations and CMS guidance, providers knew or should have known the rules when their cost reports were settled. CMS regulations and guidance permit the reopening of cost reports (by Medicare contractors)

beyond 3 years for fraud or similar fault. We believe that these regulations and guidance (footnote 7) apply to these 59 unrefereed cost reports.

### *Claims That Could Not Be Recalculated*

The 110 cost reports that were not referred included 1,896 claims with \$2,261,341 in associated outlier payments. We were unable to recalculate these claims either because (1) we could not verify the original outlier payment calculations for particular claims, (2) particular claims required specialized recalculations for their outlier payments, or (3) the claims were for rehabilitation hospitals and required specialized recalculations. Our previous reviews therefore set aside the \$2,261,341 for resolution by the Medicare contractors and CMS. We have separately provided detailed data on the claims we could not recalculate to the Medicare contractors.

### **Cost Reports That Qualified for Outlier Payments and That Were Referred to CMS but Whose Associated Outlier Payments Were Not Reconciled**

Of the 287 referred cost reports whose outlier payments qualified for reconciliation, Medicare contractors reconciled the outlier payments associated with 134 cost reports by December 31, 2011. However, CMS did not ensure that Medicare contractors reconciled the outlier payments associated with 153 cost reports by that date.

We calculated in those previous reviews that the financial impact of the 153 referred cost reports whose outlier payments had not been reconciled totaled \$298,878,783 that was due to Medicare and \$17,302,431 that was due to hospitals. As discussed below and in Appendix D, Table 3, most of these 153 cost reports were within the 3-year reopening limit and some were outside that limit; these cost reports also included claims that we were unable to recalculate.

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

Of the 153 referred cost reports whose outlier payments qualified for reconciliation, 148 had not been settled or were settled and reopened within the 3-year reopening limit; the outlier payments associated with these 148 cost reports should have been reconciled but were not. The statuses (as of the data cutoff dates established for the individual Medicare contractor reviews in our previous reports; Appendix A) of the 148 cost reports that were within the 3-year reopening limit and that had unreconciled outlier payments were as follows:

- 62 cost reports were on hold because CMS had not calculated revised SSI ratios;
- 38 cost reports had received CMS approval to reconcile the outlier payments and were undergoing the reconciliation process;
- 20 cost reports were pending updates to the FISS Lump Sum Utility software;

- 14 cost reports were awaiting CMS approval to reconcile the outlier payments;
- 9 cost reports were on hold because of a combination of two reasons: CMS had not calculated revised SSI ratios and pending updates to the FISS Lump Sum Utility Software prevented the recalculation of outlier payments;
- 2 cost reports were on hold because the hospitals had appealed the time-value-of-money calculations;
- 2 cost reports were on hold because of a congressional inquiry; and
- 1 cost report was on hold because it was awaiting CMS resolution of other issues.

For the 38 cost reports that had received CMS approval and were undergoing the reconciliation process, the Medicare contractors' policies and procedures did not ensure that the contractors reconciled all the outlier payments associated with all referred cost reports that qualified for reconciliation in accordance with Federal guidelines. For the other 110 cost reports that were referred but whose outlier payments had not been reconciled, CMS was primarily responsible for the delays associated with 106 cost reports and external entities were primarily responsible for the delays associated with the other 4 cost reports.

We calculated in those previous reviews that as of December 31, 2011, the financial impact of the outlier payments associated with these 148 cost reports totaled at least \$295,648,963 in funds due to Medicare (127 cost reports) and \$17,010,771 in funds due to hospitals (21 cost reports). Of these amounts, CMS was primarily responsible for \$181,680,139 in funds due to Medicare (90 of the 106 cost reports for which CMS was primarily responsible) and for \$12,996,478 in funds due to hospitals (16 of those 106 cost reports).

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

Of the 153 referred cost reports whose outlier payments qualified for reconciliation, the remaining 5 cost reports were brought to final settlement, but their associated outlier payments were not reconciled within the 3-year reopening limit. The Medicare contractors did not reconcile these five cost reports because:

- the Medicare contractors' policies and procedures did not ensure that the contractors reopened all referred cost reports and reconciled all outlier payments in accordance with Federal guidelines (two cost reports);

- for one cost report, the previous Medicare contractor<sup>18</sup> did not correctly perform the reconciliation test, concluded that the cost report did not qualify for reconciliation, re-performed the reconciliation test, then referred the cost report to CMS for reconciliation, but did not reopen the cost report (one cost report);
- the cost report had exceeded the 3-year reopening limit by the time the Medicare contractor became responsible for it (one cost report); and
- CMS instructed the Medicare contractor to settle the cost report because CMS did not have any procedures in place to accomplish the outlier reconciliation at the time of the cost report referral (one cost report).

For the five cost reports that exceeded the 3-year reopening limit and whose outlier payments the Medicare contractors did not reconcile by December 31, 2011, we calculated in our previous reviews that as of that date the financial impact of the outlier payments totaled at least \$3,229,820 that may be due to Medicare (three cost reports) and \$291,660 that may be due to hospitals (two cost reports). Of these amounts, CMS was primarily responsible for \$2,245,825 that may be due to Medicare (one cost report).

Because the outlier reconciliation rules are promulgated in Federal regulations and CMS guidance, providers knew or should have known the rules when their cost reports were settled. CMS regulations and guidance permit the reopening of cost reports (by Medicare contractors) beyond 3 years for fraud or similar fault. We believe that these regulations and guidance (footnote 7) apply to these five referred cost reports.

#### *Claims That Could Not Be Recalculated*

The 153 referred cost reports with unreconciled outlier payments included 1,079 claims with \$8,125,337 in associated outlier payments. We were unable to recalculate these claims either because (1) we could not verify the original outlier payment calculations for particular claims, (2) particular claims required specialized recalculations for their outlier payments, or (3) the claims were for rehabilitation hospitals and required specialized recalculations. Our previous reviews therefore set aside the \$8,125,337 for resolution by the Medicare contractors and CMS. We have separately provided detailed data on the claims we could not recalculate to the Medicare contractors.

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<sup>18</sup> Responsibility for this cost report shifted from the previous Medicare contractor (which performed both reconciliation tests and referred the cost report but did not reopen it) to a different contractor. See "Consolidation of the Medicare Contractors" earlier in this report.

## **Cost Reports With Unreliable Cost-to-Charge Ratios and Whose Outlier Payments Qualified for Reconciliation**

Of the 465 cost reports with outlier payments that qualified for reconciliation, 68 cost reports had unreliable CCRs because their cost report data may not have accurately reflected the actual ratio of costs incurred to charges billed. Of these 68 cost reports, Medicare contractors referred 17 cost reports to CMS in accordance with Federal guidelines; we discuss these 17 cost reports later in this section. However, Medicare contractors did not refer 51 cost reports that should have been referred to CMS for reconciliation. See also Appendix E.

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 (chap. 3, § 20.1.2.1).<sup>19</sup> Some hospitals, though, did not use a formal charge structure and may, instead, have billed a flat fee for services or decided 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 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 Federal regulations (42 CFR § 412.84(i)(3)) permit Medicare contractors to use statewide average CCRs<sup>20</sup> 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 (42 CFR § 412.84(i)(4)).

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

Of the 51 unreferred cost reports with unreliable CCRs, 34 had not been settled as of the data cutoff dates established for the individual Medicare contractor reviews (Appendix A), but 17 had been settled and had exceeded the 3-year reopening limit.

The Medicare contractors did not refer the 51 cost reports because they had not established adequate controls to ensure that they identified all cost reports whose outlier payments qualified for reconciliation and, if necessary, were reopened before the 3-year reopening limit. Specifically:

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<sup>19</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.

<sup>20</sup> Federal regulations effectively eliminated the use of the statewide average CCR for hospitals with a CCR that falls below the former CMS-established thresholds (42 CFR § 412.84(i)(2)).

- the Medicare contractors did not perform the reconciliation test to identify and refer 37 cost reports that qualified for reconciliation<sup>21</sup> and
- the Medicare contractors 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>22</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 CCRs or CMS-approved alternative CCRs), we were unable to calculate the financial impact for these cost reports. Our previous reviews therefore set aside the 79,359 claims and \$129,113,278 in associated outlier payments for resolution by the Medicare contractors 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, Medicare contractors had not reconciled the outlier payments associated with any of these cost reports by December 31, 2011. The Medicare contractors 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 (as of the data cutoff dates established for the individual Medicare contractor reviews; Appendix A) 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.

CMS was primarily responsible for the delays of these 17 cost reports.

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, in our previous reviews, we set aside the associated 9,555 claims and \$15,792,301 in associated outlier payments for resolution by the Medicare contractors and CMS.

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<sup>21</sup> Nineteen of these cost reports were also on hold because of the SSI-related litigation, and 3 other cost reports had exceeded the 3-year reopening limit; both of these factors are discussed in “Background.”

<sup>22</sup> These 14 cost reports had exceeded the 3-year reopening limit discussed in “Background.”

### *Summary of Cost Reports With Unreliable Cost-to-Charge Ratios*

The combined financial impact of the 68 cost reports with unreliable CCRs was composed of both the 51 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. Our previous reviews therefore set aside 88,914 claims (79,359 + 9,555) and \$144,905,579 in outlier payments (\$129,113,278 + \$15,792,301) that were associated with these 68 cost reports for resolution by the Medicare contractors and CMS; see Appendix E.

### **Summary of Outlier Payments Associated With Claims That We Were Unable to Recalculate**

Our previous reviews also set aside for resolution by the Medicare contractors and CMS outlier payments that were associated with claims that we were unable to recalculate because certain hospitals required specialized recalculations for their outlier payments.<sup>23</sup> Accordingly, we could not recalculate a total of 2,975 claims with \$10,386,678 in associated outlier payments that our previous reviews set aside and that are awaiting resolution.

### **SYSTEM NEEDED TO IDENTIFY AND TRACK REFERRED COST REPORTS AND TO RECALCULATE OUTLIER PAYMENTS**

From October 1, 2003, through March 31, 2011, when it had the responsibility to perform reconciliations, CMS did not implement an automated system that would recalculate outlier payments using actual CCRs without adversely affecting other data. In addition, CMS did not maintain a complete listing of the cost reports that Medicare contractors had referred for reconciliation.

Moreover, CMS did not always ensure, after the April 1, 2011, shift in responsibility, that Medicare contractors correctly identified cost reports that qualified for reconciliation, referred all qualifying cost reports to CMS for reconciliation, and reconciled the outlier payments associated with the referred cost reports by December 31, 2011.<sup>24</sup>

The lack of a complete and up-to-date listing of referred cost reports influenced CMS's ability to track these cost reports on the individual basis necessary to ensure that every cost report that qualified for outlier payments was identified and correctly processed. The absence of this listing, along with the absence of an automated system that could use actual CCRs to recalculate outlier payments without adversely affecting other data, constituted system limitations that prevented CMS from being able to perform reconciliations when it was

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<sup>23</sup> We are here aggregating information discussed in several earlier sections of this report. The 110 cost reports that should have been referred for reconciliation but were not included 1,896 claims, with \$2,261,341 in associated outlier payments, that we were unable to recalculate. The 153 referred cost reports with unreconciled outlier payments included 1,079 claims, with \$8,125,337, that we were unable to recalculate.

<sup>24</sup> See footnote 12 earlier in this report for an explanation of the December 31, 2011, cutoff date.

responsible for reconciling outlier payments. CMS acknowledged the effects of these system limitations on its ability to perform reconciliations: “[D]ue to system limitations, we were unable to reconcile any hospital outlier claims paid under the IPPS, IRF PPS, LTCH PPS and OPSS. We also did not provide a process for Medicare contractors on how to reconcile outlier claims for those providers already flagged for outlier reconciliation under the IPPS, IRF PPS, LTCH PPS and OPSS or that could potentially be flagged for outlier reconciliation” (CMS Transmittal 2111; see also footnote 10 earlier in this report).

## **SUMMARY OF FINANCIAL IMPACT TO MEDICARE**

We calculated in our previous reviews that the net financial impact of the unreferral cost reports combined with the unreconciled outlier payments was \$425,893,413 in funds due to Medicare.

### **Financial Impact of Unreferred Cost Reports**

As of December 31, 2011, the financial impact of the outlier payments associated with the 50 unreferral cost reports that were within the 3-year reopening limit totaled at least \$81,917,455 in funds due to Medicare (43 cost reports) and \$7,431,037 in funds due to hospitals (7 cost reports). Therefore, the net financial impact to Medicare of these 50 unreferral cost reports was at least \$74,486,418. These cost reports should have been referred to CMS for reconciliation but were not; their associated outlier payments were not reconciled even though the cost reports qualified for reconciliation.

Also as of December 31, 2011, the financial impact of the outlier payments associated with the 59 cost reports that exceeded the 3-year reopening limit and that should have been referred to CMS for reconciliation but were not totaled at least \$73,508,182 that may be due to Medicare (54 cost reports) and \$4,078,047 that may be due to hospitals (5 cost reports). Therefore, the net financial impact of these 59 unreferral cost reports was at least \$69,430,135 that may be due to Medicare.

### **Financial Impact of Referred Cost Reports With Outlier Payments That Were Not Reconciled**

For the 148 referred cost reports that were within the 3-year reopening limit and whose outlier payments Medicare contractors did not reconcile by December 31, 2011, the financial impact of those outlier payments totaled at least \$295,648,963 in funds due to Medicare (127 cost reports) and \$17,010,771 in funds due to hospitals (21 cost reports). Therefore, the net financial impact to Medicare of these 148 cost reports with unreconciled outlier payments was at least \$278,638,192.

For the five referred cost reports that exceeded the 3-year reopening limit and whose outlier payments the Medicare contractors did not reconcile by December 31, 2011, the financial impact of those outlier payments totaled at least \$3,229,820 that may be due to Medicare (three cost reports) and \$291,660 that may be due to hospitals (two cost reports). Therefore,

the net financial impact of these five cost reports with unreconciled outlier payments was at least \$2,938,160 that may be due to Medicare.

The financial impact summarized here does not take into account the amounts that we have set aside for resolution by Medicare contractors and CMS: the amounts associated with the 2,975 claims that we were unable to recalculate, as well as the amounts associated with the 68 cost reports with unreliable CCRs.

## **UPDATED STATUS OF MEDICARE COST REPORT REFERRAL AND RECONCILIATION OF OUTLIER PAYMENTS**

As part of the normal audit resolution process for each of our previous reviews, CMS has worked with Medicare contractors to address and resolve the issues we had identified about both cost report referral and reconciliation. After the audit periods of those previous reviews and concurrent with our audit work for this review, CMS provided us with information updating the status of those cost reports and of outlier payments.

Our previous series of reviews identified 465 cost reports that, as of December 31, 2011, qualified for reconciliation of outlier payments. As of that date, 134 of the 465 cost reports had had their outlier payments reconciled. CMS has confirmed that as of November 15, 2016:

- 173 of those 465 cost reports have had their outlier payments reconciled;
- 81 of the remaining 292 cost reports exceeded the 3-year reopening limit and thus have not been reopened and have not had their associated outlier payments reconciled; and
- the other 211 (of the remaining 292) cost reports are within the 3-year reopening limit, qualify for reconciliation of outlier payments, and, according to CMS, are under review by CMS and are pending completion of the reconciliation process.

## **RECOMMENDATIONS**

We recommend that CMS:

- ensure that the Medicare contractors are continuing to take the corrective actions that we recommended in our previous series of reviews, to include collecting identified overpayments and returning those funds to either Medicare or hospitals;
- determine whether the cost reports that had exceeded the 3-year reopening limit may be reopened due to similar fault and, if so, work with the Medicare contractors to reopen them;

- ensure that the Medicare contractors review all cost reports submitted since the end of the audit periods in our previous reviews and ensure that those whose outlier payments qualified for reconciliation are correctly identified, referred, and reconciled in accordance with Federal guidelines; and
- maintain a system that identifies and tracks all cost reports that Medicare contractors have referred for reconciliation and that recalculates outlier payments on the basis of claim submissions made by hospitals.

### **CMS COMMENTS**

In written comments on our draft report, CMS concurred with our first and fourth recommendations and described corrective actions that it had taken. Although CMS did not directly agree or disagree with our other two recommendations, it described corrective actions that it had taken or planned to take that were in keeping with those recommendations. CMS said that it recognizes the importance of accurate and timely outlier payments and described its corrective actions as “formalizing the process, educating Medicare contractors, and increasing oversight.”

CMS’s comments appear in their entirety as Appendix F.

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

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>National Government Services, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-05-11-00016</a>	9/28/15
<i>Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 1</i>	<a href="#">A-07-13-02795</a>	7/22/15
<i>CGS Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-07-13-02791</a>	5/29/15
<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>	4/23/15
<i>National Heritage Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-05-11-00024</a>	4/21/15
<i>Cahaba Government Benefits Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	<a href="#">A-05-11-00019</a>	3/30/15
<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>	3/27/15
<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>	3/27/15
<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>	3/16/15
<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

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<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>	6/10/14
<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>	6/28/12

## APPENDIX B: AUDIT SCOPE AND METHODOLOGY

### SCOPE

In our previous series of reviews of individual Medicare contractors (Appendix A), we compared records from the HCRIS database to information received from the Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008. We did so to determine whether Medicare contractors 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>25</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, where necessary, recalculated the outlier payments and determined the amounts due (including associated interest) to Medicare or to hospitals.

For this rollup review, we summarized and, where necessary, updated our findings from our previous reviews of the individual Medicare contractors. We also evaluated CMS's requirements and policy regarding cost report referral and reconciliation of outlier payments, to include the reconciliation thresholds currently in place.

We performed audit work for this rollup review from October 2010 to December 2014.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to 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 officials from Medicare contractors to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;

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<sup>25</sup> Although the CMS-established deadline for reconciling the cost reports was October 1, 2011, for the individual Medicare contractor reviews we provided a 3-month grace period by establishing December 31, 2011, as our cutoff date.

- reviewed Medicare contractors' policies and procedures regarding referral to CMS and reconciliation of cost reports;
- obtained and reviewed the list of cost reports, with supporting documentation, that Medicare contractors had referred to CMS for reconciliation during our audit periods;
- obtained the cost report data from CMS's HCRIS database for cost reports with FY ends during our audit periods;
- 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 the HCRIS database to identify acute-care and long-term-care cost reports that had greater than \$500,000 in outlier payments<sup>26</sup> and
  - using the information in the HCRIS database and PSF data to calculate and compare the actual and weighted average CCRs to determine whether the resulting variance was greater than plus or minus 10 percentage points;
- verified that Medicare contractors used the three different types of outlier payments specified by Federal regulations (short-stay, operating, and capital)<sup>27</sup> to determine whether the cost reports qualified for reconciliation;
- requested that Medicare contractors provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;<sup>28</sup>
- reviewed Medicare contractors' responses and categorized the cost reports according to their respective statuses;
- verified that Medicare contractors had referred the cost reports before the dates of the respective audit notification letters;
- verified that all of the cost reports we reviewed met the criteria for reconciliation;

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<sup>26</sup> CMS cost report data included operating and capital payments but did not include short-stay outlier payments.

<sup>27</sup> Claims Processing Manual, chap. 3, § 20.1.2.5.

<sup>28</sup> Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by Medicare contractors.

- performed the following actions for cost reports that qualified for reconciliation but for which Medicare contractors did not recalculate the outlier payments:
  - obtained the detailed Provider Statistical & Reimbursement reports from Medicare contractors 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>29</sup>
  - recalculated, using the actual CCRs, the outlier payment amounts for those cost reports whose outlier payments Medicare contractors did not recalculate;
  - 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 hospitals 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>30</sup> as of the dates that the cost reports were referred to CMS (and 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 amounts due to or from Medicare;
- provided the results of this review to CMS officials on August 11, 2016; and
- coordinated with CMS to obtain updated status of cost report referral and reconciliation of outlier payments; analyzed these updated data; and incorporated that information into this report.

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>29</sup> We set aside claims whose original outlier payments we could not verify.

<sup>30</sup> In calculating interest, we referred to the Claims Processing Manual, chap. 3, § 20.1.2.6.

## APPENDIX C: FEDERAL REQUIREMENTS AND GUIDANCE

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)).

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 (42 CFR § 405.1885(b)); see also footnote 7 earlier in this report for regulations and guidance that permit the reopening of cost reports beyond 3 years.

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

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, chap. 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 directed the Medicare contractors to assume the responsibility to perform backlogged reconciliations effective April 1, 2011, as well as all future reconciliations, although the CMS Central Office would determine whether reconciliations would be performed. In this document, CMS also stated that it had not performed reconciliations because of system limitations.

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 the audit periods of our previous reviews 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).

CMS instructs a Medicare contractor to determine acceptability of a submitted cost report within 30 days of receipt of that cost report (CMS's *Provider Reimbursement Manual*, part 2, § 140).

**APPENDIX D: SUMMARY OF AMOUNTS DUE TO MEDICARE OR HOSPITALS  
BY COST REPORT CATEGORY**

**Table 2: Total Cost Reports and Amounts Due**

<b>Grand Total</b>	<b>Due to Medicare</b>	<b>Due to Hospitals</b>
<b>465 Cost Reports</b>	<b>\$622,947,518</b>	<b>\$57,238,736</b>

**Table 3: Cost Reports Not Referred (OIG Identified)**

<b>Cost Report Category</b>	<b>Reconciled</b>	<b>Not Reconciled</b>				<b>Total</b>
		<b>Within 3 Years</b>		<b>After 3 Years</b>	<b>Not Reconciled Subtotal</b>	
		<b>In Process</b>	<b>On Hold</b>			
<b>Number of Cost Reports</b>	1	22	28	59	109	<b>110</b>
<b>Balance Due to Medicare</b>	\$353,960	\$27,272,139	\$40,004,635	\$56,879,529	\$124,156,303	\$124,510,263
<b>Interest Due to Medicare</b>	46,548	6,277,728	8,362,953	16,628,653	31,269,334	31,315,882
<b>Balance Due to Hospitals</b>	0	4,552,904	1,354,138	3,130,166	9,037,208	9,037,208
<b>Interest Due to Hospitals</b>	0	1,163,181	360,814	947,881	2,471,876	2,471,876
<b>Total Due to Medicare</b>	<b>\$400,508</b>	<b>\$33,549,867</b>	<b>\$48,367,588</b>	<b>\$73,508,182</b>	<b>\$155,425,637</b>	<b>\$155,826,145</b>
<b>Total Due to Hospitals</b>	<b>\$0</b>	<b>\$5,716,085</b>	<b>\$1,714,952</b>	<b>\$4,078,047</b>	<b>\$11,509,084</b>	<b>\$11,509,084</b>

**Note:** The dollar amounts associated with these cost reports do not reflect the 1,896 claims that we were unable to recalculate.

**Table 4: Cost Reports Referred (Medicare Contractor Identified)  
but Outlier Payments Not Reconciled**

Cost Report Category	Reconciled	Not Reconciled			Not Reconciled Subtotal	Total
		Within 3 Years		After 3 Years		
		In Process	On Hold			
<b>Number of Cost Reports</b>	134	74	74	5	153	<b>287</b>
<b>Balance Due to Medicare</b>	\$152,244,395	\$125,737,219	\$139,132,287	\$2,885,503	\$267,755,009	\$419,999,404
<b>Interest Due to Medicare</b>	15,998,195	15,131,433	15,648,024	344,317	31,123,774	47,121,969
<b>Balance Due to Hospitals</b>	25,803,489	10,359,980	4,955,801	223,767	15,539,548	41,343,037
<b>Interest Due to Hospitals</b>	2,623,732	1,294,461	400,529	67,893	1,762,883	4,386,615
<b>Total Due to Medicare</b>	<b>\$168,242,590</b>	<b>\$140,868,652</b>	<b>\$154,780,311</b>	<b>\$3,229,820</b>	<b>\$298,878,783</b>	<b>\$467,121,373</b>
<b>Total Due to Hospitals</b>	<b>\$28,427,221</b>	<b>\$11,654,441</b>	<b>\$5,356,330</b>	<b>\$291,660</b>	<b>\$17,302,431</b>	<b>\$45,729,652</b>

**Note:** The dollar amounts associated with these cost reports do not reflect the 1,079 claims that we were unable to recalculate.

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

**Table 5: Total Cost Reports With Unreliable Cost-to-Charge Ratios and Amounts Set Aside**

<b>Grand Total</b>	<b>Claims Set Aside</b>	<b>Outlier Payments Set Aside</b>
<b>68 Cost Reports</b>	<b>88,914 claims</b>	<b>\$144,905,579</b>

**Table 6: Cost Reports With Unreliable Cost-to-Charge Ratios That Were Not Referred (OIG Identified)**

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		After 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
Number of Cost Reports	0	12	22	17	51	51
Number of Claims Set Aside	0	23,748	45,252	10,359	79,359	79,359
Outlier Payments Set Aside	\$0	\$29,539,023	\$80,841,599	\$18,732,656	\$129,113,278	\$129,113,278

**Table 7: Cost Reports With Unreliable Cost-to-Charge Ratios That Were Referred (Medicare Contractor Identified)**

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		After 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
Number of Cost Reports	0	2	15	0	17	17
Number of Claims Set Aside	0	387	9,168	0	9,555	9,555
Outlier Payments Set Aside	\$0	\$5,224,670	\$10,567,631	\$0	\$15,792,301	\$15,792,301



**APPENDIX F: CMS COMMENTS**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW  
Washington, DC 20201

**DATE:** AUG 16 2017

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Seema Verma  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Vulnerabilities Remain in Medicare Hospital Outlier Payments (A-07-14-02800)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General’s (OIG) draft report. CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by ensuring proper payments to providers and facilities.

CMS uses a prospective payment system (PPS) to pay hospitals for providing inpatient hospital services to Medicare beneficiaries. Section 1886(d)(5)(A) of the Social Security Act provides for supplemental Medicare payments to Medicare-participating hospitals, known as outlier payments, in addition to the basic prospective payments to account for cases incurring extraordinarily high costs. In order to qualify for an outlier payment, a case must have costs above a certain threshold amount.

Medicare contractors calculate outlier payments on the basis of claim submissions made by the hospitals and by using hospital-specific cost-to-charge ratios. A hospital’s cost-to-charge ratio is determined by the settlement of their cost report which hospitals are required to submit annually. These cost reports include information such as utilization data, financial statement data, as well as information pertaining to outlier payments.

Medicare contractors evaluate the cost reports to identify the potential need to reconcile outlier payments. High cost outlier payments may be reconciled upon cost report settlement to account for differences between the cost-to-charge ratio used to pay the claim at its original submission by the hospital and the cost-to-charge ratio determined at final settlement of the cost reporting period during which the discharge occurred. If a Medicare contractor determines that certain reconciliation criteria are met, the cost report is forwarded to CMS for review and determination of whether reconciliation is appropriate. Once CMS determines that reconciliation is appropriate and approves the request to reconcile outlier payments, the Medicare contractor will then process the claims for outlier reconciliation.

CMS recognizes the importance of accurate and timely outlier payments and as such, CMS has taken actions to ensure that cost reports with outlier payments are correctly identified, referred, and reconciled by formalizing the process, educating Medicare contractors, and increasing oversight.

OIG's recommendations and CMS' responses are below.

**OIG Recommendation**

The OIG recommends that CMS ensure that the Medicare contractors are continuing to take the corrective actions that we recommended in our previous series of reviews, to include collecting identified overpayments and returning those funds to either Medicare or hospitals.

**CMS Response**

CMS concurs with this recommendation. CMS will continue to work with the Medicare contractors to consider the best options for incorporating the OIG recommendations into their practices.

**OIG Recommendation**

The OIG recommends that CMS determine whether the cost reports that had exceeded the 3-year reopening limit may be reopened due to similar fault and, if so, work with the Medicare contractors to reopen them.

**CMS Response**

CMS regulations allow for the reopening of a cost report within 3 years of the determination or decision date or at any time if it is established that the determination or decision was procured by fraud or similar fault. CMS will explore if there is more conclusive evidence of similar fault, and consider appropriate actions if such evidence should be found.

**OIG Recommendation**

The OIG recommends that CMS ensure that the Medicare contractors review all cost reports submitted since the end of the audit periods in our previous reviews and ensure that those whose outlier payments qualified for reconciliation are correctly identified, referred, and reconciled in accordance with Federal guidelines.

**CMS Response**

CMS will continue to instruct the Medicare contractors to review prospective cost reports for outlier reconciliation. Additionally, since the end of the audit periods in previous reviews, CMS has worked to improve the quality surveillance program to monitor that cost reports whose outlier payments qualified for reconciliation are correctly identified and referred.

**OIG Recommendation**

The OIG recommends that CMS maintain a system that identifies and tracks all cost reports that Medicare contractors have referred for reconciliation and that recalculates outlier payments on the basis of claim submissions made by hospitals.

**CMS Response**

CMS concurs with this recommendation. CMS currently maintains a system that identifies and tracks all cost reports that Medicare contractors have referred for reconciliation and a system that recalculates outlier payments on the basis of claim submissions made by hospitals for those cost reports that CMS approves for reconciliation.