

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FIRST COAST SERVICE OPTIONS, INC.,
DID NOT ALWAYS REFER MEDICARE
COST REPORTS AND RECONCILE
OUTLIER PAYMENTS**

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March 2015
A-05-11-00022

Office of Inspector General

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EXECUTIVE SUMMARY

First Coast Service Options, Inc., did not always refer cost reports whose outlier payments qualified for reconciliation to the Centers for Medicare & Medicaid Services. The financial impact of the unreferral cost reports was \$472,000 that should be recouped from health care providers and returned to Medicare. In addition, First Coast 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, First Coast Service Options, Inc. (First Coast), has been since 2008 the Medicare contractor for Jurisdiction 9, which comprises Florida, Puerto Rico, and the U.S. Virgin Islands.

The objectives of this review were to determine whether First Coast (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 for 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 (CCR). 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 First Coast 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 six cost reports with outlier payments that qualified for reconciliation, First Coast referred three cost reports to CMS in accordance with Federal guidelines. However, First Coast did not refer three cost reports that should have been referred to CMS for reconciliation. Of these three, one cost report had not been settled and should have been referred to CMS for reconciliation. As of December 31, 2011, the difference between the outlier payments associated with this cost report and the recalculated outlier payments totaled \$472,047. We refer to this difference as "financial impact." The two remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. We calculated that the financial impact of the outlier payments associated with those two cost reports totaled at least \$799,481.

Of the three cost reports that were referred to CMS with outlier payments that qualified for reconciliation, First Coast had reconciled the outlier payments associated with one cost report by December 31, 2011. However, First Coast had not reconciled the outlier payments associated with the remaining two cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with the two cost reports that were referred but not reconciled was \$5,015,154.

Because certain claims require specialized recalculations for their outlier payments, we were unable to recalculate 1,727 of the 1,765 claims associated with the cost reports that we were recalculating and are setting aside \$747,437 in outlier payments associated with those claims for resolution by First Coast and CMS.

WHAT WE RECOMMEND

We recommend that First Coast:

- review one 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 \$472,047 in funds and associated interest from a health care provider, and refund that amount to the Federal Government;
- review the two 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 \$799,481 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the two cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$5,015,154 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare;
- work with CMS to resolve the \$747,437 in outlier payments associated with the 1,727 claims that we could not recalculate;
- ensure control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified, referred, and, if necessary, reopened before the 3-year reopening limit;
- ensure policies and procedures are in place so that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, First Coast partially concurred with our recommendations and described corrective actions that it had taken. First Coast stated that it could not reopen two cost reports that had been settled and had exceeded the 3-year reopening limit. First Coast also specified that one of these two cost reports did not qualify for referral because the CCR was greater than the ceiling, and the provider was appropriately paid at the default ratios in effect at the time. In addition, First Coast asked us to remove our finding related to the two cost reports identified in our third recommendation because these cost reports were placed on a Supplemental Security Income (SSI) hold under the direction of CMS. First Coast concurred with our remaining three recommendations pertaining to its policies, procedures, and controls related to the outlier reconciliation process.

After reviewing First Coast's comments, we maintain that all of our findings and recommendations are valid.

With respect to the two cost reports associated with our second recommendation, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "similar fault." Also, claims associated with one of these cost reports were appropriately paid using a Statewide average CCR because First Coast was unable to determine an accurate actual CCR. Although Medicare contractors may use Statewide average CCRs to pay claims during the cost reporting period, CMS guidance 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. On the basis of CMS's guidance, we determined that the cost report qualified for outlier payment reconciliation and should have been referred to CMS.

First Coast had not reconciled the outlier payments associated with the two cost reports identified in our third recommendation by December 31, 2011, because CMS had not calculated revised SSI ratios. In our report, we emphasize that CMS bore principal responsibility for the delays with reconciliation.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

In a previous Office of Inspector General (OIG) audit, we reported to CMS that 292 cost reports referred by 9 Medicare contractors for reconciliation had not been settled.² In that audit we reviewed outlier cost report data submitted to CMS by 9 selected Medicare contractors that served a total of 15 jurisdictions during our audit period (October 1, 2003, through December 31, 2008). To follow up on that audit, we performed a series of reviews to determine whether the Medicare contractors had (1) referred the cost reports that qualified for reconciliation (a responsibility that already rested with the contractors) and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility.³ One such contractor, First Coast Service Options, Inc. (First Coast), has been since 2008 the Medicare contractor for Jurisdiction 9, which comprises Florida, Puerto Rico, and the U.S. Virgin Islands.

OBJECTIVES

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

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

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

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

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

BACKGROUND

Medicare and Outlier Payments

Under Title XVIII of the Social Security Act (the Act), Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS administers the program and uses a prospective payment system (PPS) to pay Medicare-participating hospitals (hospitals) for providing inpatient hospital services to Medicare beneficiaries. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.

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

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

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

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

To qualify for outlier payments, a claim must have costs that exceed a CMS-established cost threshold. Costs are calculated by multiplying covered charges by a hospital-specific CCR. Because a hospital's actual CCR for any given cost-reporting period cannot be known until final settlement of the cost report for that year, the Medicare contractors calculate and make outlier payments using the most current information available when processing a claim. For discharges occurring on or after October 1, 2003, the CCR applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period (42 CFR § 412.84(i)(2)). More than one CCR can be used in a cost reporting period.

A hospital must submit its cost reports, which can include outlier payments, to Medicare contractors within 5 months after the hospital's fiscal year (FY) ends. CMS instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report (*Provider*

Reimbursement Manual, part 2, § 140). After accepting a cost report,⁵ the Medicare contractor completes its preliminary review and may issue a tentative settlement to the hospital. In general, Medicare contractors perform tentative settlements to make partial payments to hospitals owed Medicare funds (although in some cases a tentative settlement may result in a payment from a hospital to Medicare). This practice helps ensure that hospitals are not penalized because of possible delays in the final settlement process.

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

The Medicare contractor reviews the cost report and may audit it before final settlement. If a cost report is audited, the Medicare contractor incorporates any necessary adjustments to identify reimbursable amounts and finalize Medicare reimbursements due from or to hospitals.⁶ At the end of this process, the Medicare contractor issues the final settlement document, the Notice of Program Reimbursement (NPR), to the hospital. The NPR shows whether payment is owed to Medicare or to the hospital. The final settlement thus incorporates any audit adjustments the Medicare contractor may have made.

In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years⁷ after the date of the final settlement of that cost report (42 CFR § 405.1885(b)). We refer to this as the 3-year reopening limit.

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

⁵ Medicare contractors do not accept every cost report on its initial submission. Medicare contractors can return cost reports to hospitals for correction, additional information, or other reasons.

⁶ Among other reasons, cost reports can be adjusted to reflect actual expenses incurred or to make allowances for recovery of expenses through sales or fees.

⁷ Cost reports may be reopened by Medicare contractors beyond 3 years for fraud or similar fault (42 CFR § 405.1885(b)(3); *Provider Reimbursement Manual*, part 1, § 2931.1 (F)).

CMS Changes in the Hospital Outlier Payment Reconciliation Methodology

Outlier Payment Reconciliation

CMS developed new outlier regulations⁸ and guidance in 2003 after reporting that, from Federal FYs 1998 through 2002, it paid approximately \$9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.^{9, 10} The 2003 regulations intended to ensure that outlier payments were limited to extraordinarily high-cost cases and that final outlier payments reflected an accurate assessment of the actual costs the hospital had incurred. Medicare contractors were to refer hospitals' cost reports to CMS for reconciliation so CMS could correctly re-price submitted claims and allow Medicare contractors to settle cost reports.¹¹

Reconciliation Process

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

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

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

⁸ CMS, *Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital [LTCH] Prospective Payment Systems*, 68 Fed. Reg. 34494 (Jun. 9, 2003).

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

¹⁰ CMS had projected that it would pay approximately \$17.6 billion for Medicare IPPS outlier payments but actually made approximately \$26.6 billion in payments.

¹¹ Although CMS did not instruct Medicare contractors to refer hospital cost reports in need of reconciliation until 2005, the 2003 regulations were applicable to cost reporting periods beginning on or after October 1, 2003.

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

April 1, 2011. In CMS Transmittal 2111,¹³ CMS directs the Medicare contractors to assume the responsibility to perform the reconciliations effective April 1, 2011. CMS Transmittal 2111 also says that contractors should perform reconciliations only if they receive prior approval from CMS. In that document, CMS also states that it had not performed reconciliations because of system limitations.

To process the backlog of cost reports requiring reconciliation, CMS instructed Medicare contractors to submit to CMS, between April 1 and April 25, 2011, a list of hospitals whose cost reports had been flagged for reconciliation¹⁴ before April 1, 2011. Further, CMS was to grant approval for Medicare contractors to perform reconciliations for those hospitals with open cost reports. Contractors were then to reconcile, by October 1, 2011, outlier claims that had been flagged before April 1, 2011.

CMS Lump Sum Utility Used in Outlier Recalculation

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

Cost Reports on Hold

In August 2008, CMS instructed Medicare contractors to hold for settlement, rather than settle, any cost reports affected by revised Supplemental Security Income (SSI) ratios. In addition, CMS instructed Medicare contractors to stop issuing final settlements on cost reports using the FY 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 FY 2008 and 2009 SSI ratios. The DSH/SSI hold remained in effect until CMS published the updated SSI ratios in June 2012.

HOW WE CONDUCTED THIS REVIEW

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

¹³ CMS, *Outlier Reconciliation and Other Outlier Manual Updates for IPPS, OPSS [Outpatient PPS], IRF [Inpatient Rehabilitation Facility] PPS, IPF [Inpatient Psychiatric Facility] PPS and LTCH PPS*, Claims Processing Manual, Transmittal 2111 (Change Request 7192; December 3, 2010).

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

that date and, where necessary, used CMS's database to calculate the amounts due to Medicare or to providers.

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

Appendix B contains details of our audit scope and methodology.

FINDINGS

Of six cost reports with outlier payments that qualified for reconciliation, First Coast referred three cost reports to CMS in accordance with Federal guidelines. However, First Coast did not refer three cost reports that should have been referred to CMS for reconciliation. Of these three, one cost report had not been settled and should have been referred to CMS for reconciliation. As of December 31, 2011, the difference between the outlier payments associated with this cost report and the recalculated outlier payments totaled \$472,047. We refer to this difference as "financial impact."¹⁵ The two remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. We calculated that the financial impact of the outlier payments associated with those two cost reports totaled at least \$799,481.

Of the three cost reports that were referred to CMS with outlier payments that qualified for reconciliation, First Coast had reconciled the outlier payments associated with one cost report by December 31, 2011. However, First Coast had not reconciled the outlier payments associated with the remaining two cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with the two cost reports that were referred but not reconciled was \$5,015,154.

Because certain claims require specialized recalculations for their outlier payments, we were unable to recalculate 1,727 of the 1,765 claims associated with the cost reports that we were recalculating and are setting aside \$747,437¹⁶ in outlier payments associated with those claims for resolution by First Coast and CMS.

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

¹⁵ The financial impacts that we convey in this report take the time value of money into account and thus also include any accrued interest; see also Appendix B.

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

FEDERAL REQUIREMENTS

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

If a hospital's total outlier payments during the cost reporting period exceed \$500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during that period to make outlier payments, CMS policy requires the Medicare contractor to refer the hospital's cost report to CMS for reconciliation (Claims Processing Manual, chapter 3, § 20.1.2.5).

CMS Transmittal 707 provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until April 1, 2011. In CMS Transmittal 2111, CMS directs the Medicare contractors to assume the responsibility to perform the reconciliations effective April 1, 2011, although the CMS Central Office would determine whether reconciliations would be performed. In this document, CMS also states that it had not performed reconciliations because of system limitations.

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

COST REPORTS NOT REFERRED

Of six cost reports with outlier payments that qualified for reconciliation, First Coast referred three cost reports to CMS in accordance with Federal guidelines. However, First Coast did not refer three cost reports that should have been referred to CMS for reconciliation.

Cost Reports Within the 3-Year Reopening Limit

Of the three cost reports that First Coast did not refer to CMS for reconciliation, one had been settled, had not exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation.¹⁷ Because First Coast 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 in a timely manner. As of December 31, 2011, the financial impact of the outlier payments associated with the unrefereed cost report totaled \$472,047 that was due to Medicare.

¹⁷ First Coast performed a reconciliation test and reopened this cost report after the start of our audit, but did not reconcile the outlier payments associated with this cost report as of December 31, 2011.

Cost Reports Outside the 3-Year Reopening Limit

Of the three cost reports that First Coast did not refer to CMS for reconciliation, the remaining two cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. First Coast did not refer the two cost reports to CMS because First Coast 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:

- First Coast did not perform the reconciliation test to identify and refer one cost report that qualified for reconciliation; and
- First Coast did not correctly perform the reconciliation test for one cost report and incorrectly concluded that the 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 two cost reports totaled at least \$799,481 that may be due to Medicare.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the three cost reports whose outlier payments qualified for reconciliation, First Coast reconciled the outlier payments associated with one cost report by December 31, 2011. However, First Coast had not reconciled the outlier payments associated with the remaining two cost reports by December 31, 2011, because CMS had not calculated revised SSI ratios.¹⁸ For these two 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.¹⁹

For the two referred cost reports whose outlier payments First Coast did not reconcile by December 31, 2011, the financial impact of the outlier payments was \$5,015,154 that was due to Medicare.

CLAIMS THAT COULD NOT BE RECALCULATED

To determine the financial impact of the 2 unreferred cost reports that had exceeded the 3-year reopening limit, we attempted to recalculate 1,765 claims related to these cost reports. However, we were unable to recalculate 1,727 claims with \$747,437 in associated outlier payments because they required specialized recalculations for their outlier payments. We are therefore setting aside the \$747,437 for resolution by First Coast and CMS. We are separately providing data on the claims that we could not recalculate to First Coast.

¹⁸ These two reports were on hold because of the SSI-related issue discussed in “Background.”

¹⁹ We will report to CMS on issues related to cost report referral and outlier payment reconciliation in a future review.

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with one unreferred cost report that was within the 3-year reopening limit was \$472,047 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 two 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 \$799,481 that may be due to Medicare.

Finally, for the two referred cost reports whose outlier payments First Coast did not reconcile by December 31, 2011, the financial impact of those outlier payments was \$5,015,154 that was due to Medicare.

RECOMMENDATIONS

We recommend that First Coast:

- review one 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 \$472,047 in funds and associated interest from a health care provider, and refund that amount to the Federal Government;
- review the two 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 \$799,481 in funds and associated interest from health care providers that may be due to the Federal Government;
- review the two cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$5,015,154 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare;
- work with CMS to resolve the \$747,437 in outlier payments associated with the 1,727 claims that we could not recalculate;
- ensure control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified, referred, and, if necessary, reopened before the 3-year reopening limit;
- ensure policies and procedures are in place so that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and

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

AUDITEE COMMENTS

In written comments on our draft report, First Coast partially concurred with our recommendations and described corrective actions that it had taken.

First Coast concurred with our first recommendation and stated that it had settled the cost report.

First Coast partially concurred with our second recommendation. First Coast agreed that the two cost reports had exceeded the 3-year reopening limit, but stated that it therefore could not reopen these cost reports. Moreover, First Coast specified that one of the two cost reports (that included some claims identified in our fourth recommendation) did not require a referral to CMS because the CCR was greater than the ceiling, and the provider was appropriately paid at the default ratios in effect at the time.²⁰

First Coast stated that it had settled the two cost reports identified in our third recommendation and requested that this finding be removed from the report because these two cost reports were properly placed on a SSI hold under the direction of CMS.

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

First Coast's comments appear in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing First Coast's comments, we maintain that all of our findings and recommendations are valid.

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

²⁰ Because First Coast stated that the cost report did not require a referral to CMS, First Coast did not address our finding that certain claims required specialized recalculations.

the providers associated with two unreferral cost reports procured Medicare funds by “similar fault” and work with CMS to resolve the \$799,481 in outlier payments.

In regard to the cost report mentioned in our second and fourth findings, the claims associated with this cost report were appropriately paid using a Statewide average CCR that was in effect during the cost reporting period (First Coast refers to this CCR as a “default ratio”).²¹ However, although Medicare contractors may in limited circumstances use Statewide average CCRs to pay outlier claims during the cost reporting period, the Claims Processing Manual requires Medicare contractors to use specific lines from the cost report data to calculate the actual CCRs (chapter 3, § 20.1.2.1) that are, in turn, used to determine whether a cost report qualifies for reconciliation (chapter 3, § 20.1.2.5). On the basis of the guidance that CMS provided, we determined that the cost report qualified for outlier payment reconciliation and should have been referred to CMS. Therefore, we continue to recommend that First Coast work with CMS to resolve the \$747,437 in outlier payments associated with this cost report.

First Coast had not reconciled the outlier payments associated with the two cost reports identified in our third recommendation by December 31, 2011 (the date specified in our audit objective), because CMS had not calculated revised SSI ratios and instructed Medicare contractors to hold for settlement, rather than settle, any cost reports affected by these ratios. In our report, we emphasize that CMS bore principal responsibility for the delays with reconciliation. Therefore, our finding remains valid.

²¹ 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. CMS’s *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, § 20.1.2.2, specifies that a Medicare contractor may use a Statewide average CCR if the contractor is unable to determine an accurate CCR for a hospital 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, or the Medicare contractor cannot obtain accurate data to calculate a CCR.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02774	12/16/2014
<i>Wisconsin Physicians Service Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02777	11/18/2014
<i>Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-11-02773	10/29/2014
<i>Trailblazer Health Enterprises Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required</i>	A-07-10-02776	6/10/2014
<i>The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance</i>	A-07-10-02764	6/28/2012

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether First Coast 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, 2011.²² If the cost reports had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and calculated the amounts due to Medicare or to providers.

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

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to First Coast and other Medicare contractors concerning the reconciliation process and responsibilities;
- obtained from CMS a list of cost reports that Medicare contractors had referred for reconciliation;
- held discussions with First Coast officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed First Coast'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 First Coast's jurisdiction as of November 4, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that First Coast had referred to CMS for reconciliation during our audit period;
- obtained the cost report data from CMS's database for cost reports with FY ends during our audit period;

²² Although the CMS-established deadline for reconciling the cost reports was October 1, 2011, for this review we provided a 3-month grace period by establishing December 31, 2011, as our cutoff date.

- obtained the Inpatient Acute Care and LTCH provider-specific files (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 payments²³ 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 First Coast used the three different types of outlier payments specified by Federal regulations²⁴ (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;
- requested that First Coast provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;²⁵
- reviewed First Coast’s response and categorized the cost reports according to their respective statuses;
- verified whether First Coast 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 one cost report that qualified for outlier reconciliation but for which First Coast did not recalculate the outlier payments:²⁶
 - obtained the detailed Provider Statistical & Reimbursement report from First Coast;
 - verified the original outlier payments using the CCR that was used to pay the claim;
 - recalculated the outlier payment amounts using the actual CCRs; and

²³ CMS cost report data included operating and capital payments but did not include short-stay outlier payments.

²⁴ Claims Processing Manual, chapter 3, § 20.1.2.5.

²⁵ Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by First Coast.

²⁶ We attempted to recalculate 1,727 claims related to one additional cost report. However, we were unable to recalculate these claims because they required specialized recalculations for their outlier payments.

- calculated accrued interest²⁷ 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 First Coast officials on May 1, 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.

²⁷ We calculated interest by referring to the Claims Processing Manual, § 20.1.2.6.

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

Table 1: Total Cost Reports and Amounts Due

Grand Total	Due to Medicare	Due to Provider
6 cost reports	\$6,846,065	\$0

Table 2: Cost Reports Not Referred (OIG Identified)

Cost Report Category	Reconciled	Not Reconciled			Total	
		Within 3 Years		Past 3 Years		Not Reconciled Subtotal
		In Process	On Hold			
Number of cost reports	0	1	0	2	3	
Balance due to Medicare	\$0	\$411,204	\$0	\$593,443	\$1,004,647	
Interest due to Medicare	0	60,843	0	206,038	\$266,881	
Total due to Medicare	\$0	\$472,047	\$0	\$799,481	\$1,271,528	

Note: The dollar amounts associated with these cost reports do not reflect the 1,727 claims that we were unable to recalculate.

Table 3: Cost Reports Referred (Medicare Contractor Identified)

Cost Report Category	Reconciled	Not Reconciled			Total	
		Within 3 Years		Past 3 Years		Not Reconciled Subtotal
		In Process	On Hold			
Number of cost reports	1	0	2	0	2	3
Balance due to Medicare	\$466,319	\$0	\$4,569,548	\$0	\$4,569,548	\$5,035,867
Interest due to Medicare	93,064	0	445,606	0	445,606	538,670
Total due to Medicare	\$559,383	\$0	\$5,015,154	\$0	\$5,015,154	\$5,574,537

APPENDIX D: AUDITEE COMMENTS



November 24, 2014

Sandy Coston
CEO & President
First Coast Service Options, Inc.
Sandy.coston@fco.com

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

RE: **A-05-11-00022, First Coast Service Options, Inc. Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required**

Dear Ms. Fulcher:

First Coast Service Options Inc. (First Coast) has received the U.S. Department of Health & Human Services, Office of Inspector General (OIG) draft report entitled, "First Coast Service Options, Inc. Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payment." We have reviewed the findings and recommendations, and appreciate the opportunity to provide comments prior to the release of the final report.

In the draft report, the OIG outlined seven recommendations that First Coast has addressed as indicated below. We have referenced each of these recommendations and numbered them accordingly. While some of these issues occurred under a prior contractor, COSVI, First Coast acknowledges full responsibility to resolve them, as outlined below.

Recommendation #1: Review one 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 \$472,047 in funds and associated interest from a health care provider, and refund that amount to the Federal Government.

Response #1: First Coast concurs, and has already requested approval for outlier reconciliation from CMS, and on 10/24/14 has settled this cost report with the necessary outlier reconciliation adjustments.

377 Riverside Avenue, Jacksonville, Florida, 32202
Tel: 904-781-8408
www.fco.com

Recommendation #2: Review the two 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 \$700,461 in funds and associated interest from health care providers that may be due to the Federal Government.

Response #2: Regarding provider # [REDACTED], First Coast concurs – We have reviewed this cost report and determined that it has exceeded the three-year time limit per PRM-1-§-2931.1.A., and therefore, it cannot be reopened. Regarding provider # [REDACTED], First Coast does not concur. This cost report was settled by another contractor. Upon our review and reconciliation, it was determined that the cost report did not require a referral as the DCR was greater than the ceiling, and the provider was appropriately paid at the default ratios in effect at the time – reference CR7192. We respectfully request for this finding and recommendation to be removed from the report. In addition, please note that this cost report has also exceeded the three-year time limit per PRM-1-§-2931.1.A. and therefore, it cannot be reopened.

Recommendation #3: Review the two cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$5,015,154 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare.

Response #3: First Coast concurs that the two reports required reconciliation and has already requested approval for outlier reconciliation from CMS, and on 02/26/13, we settled these cost reports with the necessary outlier reconciliation adjustments. However, we respectfully request that the finding for these two providers be dropped from this report. Under the direction of CMS, these two cost reports were properly placed on SSI hold. Once given the approval by CMS to settle cost reports that use the 2006 and 2007 SSI%^s, the reconciliations were completed and the cost reports finalized.

Recommendation #4: Work with CMS to resolve the \$747,437 in outlier payments associated with the 1,727 claims that we could not recalculate.

Response #4: Please refer to response #2 regarding provider # [REDACTED]. First Coast does not concur with this recommendation. In addition, this cost report has exceeded the three-year time limit per PRM-1-§-2931.1.A. and therefore, it cannot be reopened.

Recommendation #5: Ensure control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified, referred, and, if necessary, reopened before the 3-year reopening limit.

Response #5: First Coast concurs, and has revised the control procedures related to the Outlier Reconciliation process so that all cost reports whose outlier payments qualify for reconciliation (including LTCHs) are correctly identified, referred, and if necessary, are reopened before the 3-year reopening limit.

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

Response #6: First Coast concurs, and has revised policies and procedures related to the Outlier Reconciliation process so that we reconcile all outlier payments for all referred cost reports that qualify for reconciliation, in accordance with Federal guidelines.

Recommendation #7: Review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

Response #7: First Coast concurs, and has reviewed cost reports submitted since the end of the audit period in order to ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

Again, we appreciate the opportunity to review and provide comments prior to release of the final report. If you have any questions regarding our responses, please contact Mr. Gregory W. England at (804) 781-8364.

Sincerely,

/Sandy Castor\

cc: Gregory W. England