

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HOSPITALS RECEIVED MILLIONS
IN EXCESSIVE OUTLIER PAYMENTS
BECAUSE CMS LIMITS THE
RECONCILIATION PROCESS**

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November 2019
A-05-16-00060

Office of Inspector General

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Report in Brief

Date: November 2019

Report No. A-05-16-00060

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



Why OIG Did This Audit

Outlier claim payments are based on hospital cost reports from the latest cost-reporting period for which the cost report is either settled as final or tentatively settled. The Centers for Medicare & Medicaid Services (CMS) requires its Medicare administrative contractors to reconcile outlier payments by using information from the updated current cost-reporting period, but only if the cost report meets the following criteria: the actual cost-to-charge ratio (CCR) is found to be plus or minus 10 percentage points from the CCR applied during the payment period (10-percentage-point threshold), and the outlier payments in that cost reporting period exceed \$500,000. From fiscal years 2011 through 2014 (4-year period), CMS made more than \$18 billion in outlier payments to 3,336 hospitals that submitted 13,344 cost reports (3,336 × 4 cost reports). Of these hospitals, 972 submitted 3,888 cost reports that had outlier payments exceeding \$500,000 for each year, and 3,863 of those cost reports with outlier payments, totaling \$14.7 billion, did not meet the 10-percentage-point threshold for reconciliation.

Our objective was to determine whether CMS paid hospitals more for Medicare outlier payments than the hospitals would have been paid if their outlier payments had been reconciled.

How OIG Did This Audit

We used the claims data, information from CMS, and cost reports for a 4-year period to recalculate outlier payments based on the actual CCRs of 60 hospitals that had received \$3.5 billion in outlier payments. We also analyzed CCRs of 912 hospitals that received \$11.2 billion in outlier payments. We estimated the potential costs to Medicare administrative contractors (MACs), as well as the potential return on investment, of reconciling the 236 cost reports that did not meet the 10-percentage-point threshold.

Hospitals Received Millions in Excessive Outlier Payments Because CMS Limits the Reconciliation Process

What OIG Found

From fiscal years 2011 through 2014, CMS paid the 60 hospitals a net of \$502 million more in outlier payments than the hospitals would have been paid if their outlier payments had been reconciled. (We refer to this net amount as excessive outlier payments.) Specifically, CMS paid 53 hospitals \$541 million more than they would have been paid and 7 hospitals \$39 million less than they would have been paid over the 4-year period. CMS did not detect or recover these excessive outlier payments because the 236 associated cost reports did not meet the 10-percentage-point threshold for reconciliation.

The cost reports associated with these outlier payments did not meet CMS's 10-percentage-point threshold for reconciliation because when hospitals increased their charges at a rate higher than the rate of cost increases, this usually resulted in only a small percentage point change in their CCRs. Of the 236 cost reports of 60 hospitals that we reconciled, 216 (92 percent) had a change of less than 5 percentage points in their CCRs. In addition, 34 of the 60 hospitals received excessive outlier payments each of the 4 years in our 4-year period. Of the 3,627 cost reports that we did not reconcile but for which we determined the differences between CCRs used at the time of claim payments and the actual CCRs, 3,417 (94 percent) had a change of less than 5 percentage points in their CCRs. CMS set the 10-percentage point threshold, because it believed that the threshold would appropriately capture those hospitals whose outlier payments would be substantially inaccurate when the hospital uses the ratio from the contemporaneous cost-reporting period.

Based on the estimated time and costs that we received from 7 MACs, we estimate that the administrative burden on the MACs to reconcile the 236 cost reports that did not meet the 10-percentage-point threshold would be a minimum of \$47,200 and a maximum of \$1.7 million for 4 years, or a minimum of \$11,800 and a maximum of \$425,000 per year.

What OIG Recommends and Auditee Comments

We recommend that CMS require reconciliation of all hospital cost reports with outlier payments during a cost-reporting period. If the reconciliation requirement had been in effect for the 60 hospitals in our audit, CMS would have saved approximately \$125 million per year. In written comments on our draft report, CMS concurred with our recommendation and stated that it is evaluating the current outlier reconciliation criteria and will consider whether to propose any appropriate modifications to the outlier reconciliation policy in future rule making.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program and uses a prospective payment system (PPS) to pay hospitals for providing inpatient hospital services to Medicare beneficiaries. Medicare supplements basic PPS payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses due to unusually high-cost cases and to ensure that seriously ill patients have access to high-quality inpatient care.

Outlier claim payments are based on hospital cost reports from the latest cost-reporting period for which the cost report is either settled as final or tentatively settled. CMS requires its Medicare administrative contractors (MACs) to reconcile outlier payments by using information from the updated current cost-reporting period but only under limited circumstances (described later in this report).

From fiscal years 2011 through 2014, CMS made more than \$18 billion in outlier payments to 3,336 hospitals that submitted 13,344 cost reports (3,336 × 4 cost reports). Of these hospitals, 972 submitted 3,888 cost reports that had outlier payments exceeding \$500,000 for each year, and only 25 of those cost reports, with outlier payments totaling \$144 million, met the limited reconciliation circumstances. The remaining 3,863 cost reports, with outlier payments totaling \$14.7 billion, did not meet the limited circumstances for reconciliation. Therefore, the claims related to the 3,863 cost reports were not repriced and the differences in outlier payments were not determined.

We previously performed a series of audits (Appendix B) to determine whether MACs reconciled outlier payments in compliance with CMS requirements.

OBJECTIVE

Our objective was to determine whether CMS paid hospitals more for Medicare outlier payments than the hospitals would have been paid if their outlier payments had been reconciled.

BACKGROUND

Medicare and Outlier Payments

Under Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 years or older, people with disabilities, and people with permanent kidney disease. CMS administers the program and uses the PPS to pay hospitals for providing inpatient hospital services to Medicare beneficiaries. CMS uses MACs to, among other things, process and pay Medicare claims submitted for medical services.

Medicare supplements basic PPS payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses due to unusually high-cost cases.¹ A hospital is eligible for an outlier payment for any case in which the “charges, adjusted to cost” (the cost of care) of an inpatient stay exceed the outlier threshold.^{2, 3}

MACs determine the cost of care for inpatient stays by multiplying two values: the hospital’s total charges for the inpatient stay and its cost-to-charge ratio (CCR).⁴

Charges

The Provider Reimbursement Manual, Pub. No. 15-1, part I, chapter 22, section 2202.4, defines charges as the “regular rates established by the provider for services rendered to both beneficiaries and to other paying patients.” Charges should be related consistently to the cost of the services and uniformly applied to all inpatients and outpatients. Hospitals determine what they will charge for items and services provided to patients and are able to change their charges at any time. Medicare does not dictate to a hospital what its charges or charge structure should be.

Cost-to-Charge Ratio

A MAC determines a hospital’s CCR annually by dividing the hospital’s yearly overall Medicare costs by its yearly charges for services provided to Medicare patients (Medicare charges).⁵ The MAC takes the overall Medicare costs and the Medicare charges from the hospital’s cost report.⁶ The MAC applies the hospital’s CCR to the covered charges reported on a claim for an inpatient stay to determine the cost of care for that stay.⁷

¹ The Act § 1886(d)(5)(A).

² The Act § 1886(d)(5)(A)(ii).

³ The outlier threshold for an inpatient stay is the sum of (1) the Medicare severity diagnosis-related-group (DRG) payment, the disproportionate share hospital payment, and the indirect medical education payment for that stay, and (2) a national fixed-loss amount that is adjusted to reflect some geographical and hospital-specific factors.

⁴ 68 Fed. Reg. 34494, 34496 (June 9, 2003).

⁵ 42 CFR § 412.84(h); Medicare Claims Processing Manual (MCPM), Pub. No. 100-04, Ch. 3 § 20.1.2.1.

⁶ Hospitals are required to submit cost reports to MACs for determining the program payment annually (the Act §§ 1815(a), 1861(v)(1)(A), and 1886(f)(1) and 42 CFR §§ 413.20(b) and 413.24(a)). Hospitals must submit a cost report within 5 months of their cost-reporting fiscal year end or 30 days after receipt of valid *Provider Statistical and Reimbursement* reports from the contractor, whichever date is later (*Provider Reimbursement Manual*, part II, chapter 1, § 104).

⁷ CMS also uses the CCRs for determining Medicare Severity-DRG (MS-DRG) relative weights. For example, for determining the MS-DRG relative weights for fiscal year 2019, CMS used CCRs based on the hospital cost reports for fiscal year 2016 (83 Fed. Reg. 41144, 41258-73 (Aug 17, 2018)).

Federal regulations state that the CCRs “applied at the time a claim is processed are based on either the most recent [final] 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)). After hospitals submit their cost reports for a year, MACs know the actual CCRs for that year.

Effect of Cost and Charge Fluctuations

Changes in a hospital’s costs and charges that become effective after the end of the latest cost-reporting period for which the cost report is either settled as final or tentatively settled are not reflected in the CCRs applied at the time of claims processing. If a hospital increased charges at a higher rate than its increase in costs after the end of the latest cost-reporting period, the CCR applied at the time of claims processing will be higher than the actual CCR. When the MAC applies the higher CCR to the increased charges reported for an inpatient stay, it overestimates the cost of care for that inpatient stay. Likewise, if the hospital does not increase charges by the same rate as its increase in costs after the end of the latest cost-reporting period, the CCR applied at the time of claims processing will be lower than the actual CCR. When the MAC applies the lower CCR to the charges reported for an inpatient stay, it underestimates the cost of care for that stay. Thus, overestimated costs result in outlier overpayments, and underestimated costs result in outlier underpayments.

CMS Puts a 10-Percentage-Point Threshold on Its Outlier Reconciliation Process

To correct for situations in which hospitals would otherwise receive outlier overpayments or underpayments created by the differences between the CCRs applied at the time of claims processing and the actual CCRs, 42 CFR § 412.84(i)(4) provides for a retroactive adjustment process, known as the outlier reconciliation process. Under the reconciliation process, when certain conditions are met, the outlier payments for the submitted claims should be repriced by using the actual CCR, and outlier overpayments should be recovered from the hospitals (or additional payments made to hospitals for underpayments) as part of the cost-report settlement.

CMS established the outlier reconciliation process specifically to deter hospitals from manipulating their charges to create excessive outlier payments. When CMS issued instructions for the outlier reconciliation process, it created a threshold so that it would target only the hospitals that made changes in their CCRs that appeared to be an abusive manipulation of charges. Specifically, the program instructions provide that a hospital’s outlier claims will be reconciled at the time of the cost report’s final settlement if the cost report meets the following criteria: the actual CCR is found to be plus or minus 10 percentage points from the CCR applied during the payment period, and total outlier payments in that cost reporting period exceed \$500,000.⁸ The majority of hospitals do not meet the 10-percentage-point threshold. Thus, for

⁸ The *Medicare Claims Processing Manual*, chapter 3, § 20.1.2.5(A) (Dec. 3, 2010).

these hospitals, the outlier payments made at the time of claim processing become the final outlier payments.

HOW WE CONDUCTED THIS AUDIT

From fiscal years 2011 through 2014, CMS made more than \$18 billion in outlier payments, \$14.85 billion of which went to 972 hospitals that received at least \$500,000 in outlier payments in each of the 4 years.⁹ We selected a total of 60 hospitals for our audit—the 30 hospitals that received the highest amounts of outlier payments in Illinois and the 30 hospitals from the remaining States and District of Columbia that received the highest amounts of outlier payments.^{10, 11} The 60 hospitals received \$3.5 billion in outlier payments, which was 24 percent of the total outlier payments to the 972 hospitals.

For each of these 60 hospitals, we obtained the hospital's latest 4 cost reports for fiscal years 2011 through 2014 (the 4-year period), for a total of 240 (60 × 4 years) cost reports. For each of the 240 cost reports, we calculated the percentage-point differences between the operating CCRs applied at the time of claims processing and the actual CCRs.¹² We created a database that contained 236 cost reports with outlier payments totaling \$3.5 billion that did not meet the 10-percentage-point threshold and were not subjected to the outlier payment reconciliation process. The remaining four cost reports with outlier payments totaling \$27 million met the 10-percentage-point threshold; thus, we did not include them in our database. We recalculated outlier payments for the 236 cost reports that did not meet the 10-percentage-point threshold. We also analyzed CCRs of another 912 hospitals that received \$11.2 billion in outlier payments during the 4-year period.¹³

To determine the costs involved in reconciling hospital cost reports, we contacted the 8 MACs that cover the 12 Medicare jurisdictions and requested information about the time and cost they

⁹ The 972 hospitals do not include 63 hospitals that received at least \$500,000 in outlier payments in each of the 4 years. The cost-report data that we obtained from CMS's Healthcare Cost Report Information System (HCRIS) database for calculating CCRs for these 63 hospitals contained errors.

¹⁰ We selected 30 hospitals in Illinois because we had ready access to copies of their cost reports for fiscal years 2011 through 2014.

¹¹ The 30 hospitals outside of Illinois are located in 18 states and District of Columbia (numbers in brackets represent the number of hospitals): Alabama (1), California (7), Connecticut (1), District of Columbia (1), Florida (1), Indiana (1), Kentucky (1), Massachusetts (2), Michigan (1), Minnesota (2), Missouri (1), North Carolina (1), New York (4), Oklahoma (1), Pennsylvania (1), Tennessee (1), Texas (1), Virginia (1), and Wisconsin (1).

¹² Whenever more than one operating CCR was applied in a cost-reporting period, we calculated and used the weighted average of the operating CCRs, as required (*Medicare Claims Processing Manual*, chapter 3, "Inpatient Hospital Billing," § 20.1.2.5.C). The term "CCRs" seen throughout this report refers to the weighted average of operating CCRs, when applicable.

¹³ These 912 hospitals are the others from the 972 hospitals that were not in our 60 samples.

expend to reconcile a cost report. Seven of the MACs that cover 10 jurisdictions responded with their estimates of the time and costs related to hospital cost-report reconciliations. We used the MACs' responses to calculate an estimated cost for subjecting all 236 cost reports to the outlier reconciliation process.

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 A contains the details of our audit scope and methodology.

FINDINGS

CMS paid the 60 hospitals a net of \$502 million more in outlier payments than they would have been paid if their outlier payments had been reconciled. (We refer to this net amount as excessive outlier payments.) Specifically, CMS paid 53 hospitals \$541 million more than they would have been paid and 7 hospitals \$39 million less than they would have been paid over the 4-year audit period. CMS did not detect or recover these excessive outlier payments because the 236 associated cost reports did not meet the 10-percentage-point threshold for reconciliation.

The cost reports associated with these outlier payments did not meet CMS's 10-percentage-point threshold for reconciliation because when hospitals increased their charges at a rate higher than the rate of cost increases, this usually resulted in only a small percentage-point change in their CCRs. Of the 236 cost reports of 60 hospitals that we reconciled, 216 (92 percent) cost reports had a change of less than 5 percentage points in their CCRs. In addition, 34 of the 60 hospitals received excessive outlier payments each of the 4 years in our 4-year period. Of the 3,627 cost reports that we did not reconcile but for which we determined the differences between CCRs used at the time of claim payments and the actual CCRs, 3,417 (94 percent) cost reports had a change of less than 5 percentage points in their CCRs.

CMS set the 10-percentage-point threshold because it believed that the threshold would appropriately capture those hospitals whose outlier payments would be substantially inaccurate when they used the ratio from the contemporaneous cost-reporting period.¹⁴

CMS PAID THE 60 HOSPITALS \$502 MILLION IN EXCESSIVE OUTLIER PAYMENTS

CMS paid 60 hospitals \$502 million in excessive outlier payments. Specifically, over the 4-year audit period, CMS paid 53 hospitals \$541 million more than they would have been paid if the hospital had to reconcile their outlier payments and paid 7 hospitals \$39 million less than they

¹⁴68 Fed. Reg. 34494, 34503 (June 9, 2003)

would have been paid. CMS did not detect or recover these excessive outlier payments because the 236 associated cost reports did not meet the 10-percentage-point threshold for reconciliation.

MOST COST REPORTS DID NOT MEET CMS'S 10-PERCENTAGE-POINT THRESHOLD FOR RECONCILIATION

CMS policy does require reconciliation for cost reports only if the difference between the CCR applied at the time of claim processing and the actual CCR for that year is at or more than 10 percentage points and total outlier payments exceed \$500,000.

The cost reports associated with the excessive outlier payments did not meet CMS's 10-percentage-point threshold for reconciliation in many cases because when hospitals increased their charges at a rate higher than the rate of cost increases, the result was usually only a small percentage-point change in their CCRs. Appendix C includes an example of how significant increases in charges may only have a minor impact on a hospital's CCR and an example of how a small change in the CCR can result in a significantly higher outlier payment.

Nearly All Cost Reports Associated With Hospitals That Received Excessive Outlier Payments Had a Change of Only a Few Percentage Points in Their Cost-To-Charge Ratios

Of the 236 cost reports with \$3.5 billion in outlier payments that we reconciled, 216 cost reports (92 percent) had a change in their CCRs of less than 5 percentage points. These 216 cost reports accounted for \$449 million (89 percent) of the total \$502 million of excessive outlier payments. Further, of the 3,627 cost reports with outlier payments that we did not reconcile but did determine the differences between CCRs used at the time of claim payments and the actual CCRs, 3,417 (94 percent) cost reports had a change in their CCRs of less than 5 percentage points, as shown in Table 1 (on the next page).

Table 1: Outlier Payments and Their Related Cost Reports, by Percentage-Point Changes in the Cost-to-Charge Ratios

Percentage-Point Change in CCRs Were:	Outlier Payments Covered by This Audit				Outlier Payments Not Covered by This Audit	
	Number of Cost Reports (A)	Total Outlier Payments	Net Excessive (Under) Payments (B)	Average Excessive (Under) Payments Per Cost Report (B ÷ A)	Number of Cost Reports	Total Outlier Payments
Less than 1	68	\$915,585,723	\$26,883,122	\$395,340	1,189	\$3,492,545,113
1 or more, but less than 2	71	1,296,408,989	155,033,479	2,183,570	1,034	3,158,849,311
2 or more, but less than 3	46	672,558,329	166,779,248	3,625,636	675	2,129,732,013
3 or more, but less than 4	22	302,261,297	71,306,232	3,241,192	344	1,123,764,943
4 or more, but less than 5	9	87,375,511	29,270,447	3,252,272	175	612,841,234
Less than 5 (Subtotal)	216	\$3,274,189,849	\$449,272,528	\$2,079,965	3,417	\$10,517,732,614
5 or more, but less than 6	9	120,534,421	26,198,057	2,910,895	80	256,485,291
6 or more, but less than 7	6	58,440,456	25,108,216	4,184,703	66	213,355,442
7 or more, but less than 8	3	22,595,426	10,182,803	3,394,268	31	111,337,810
8 or more, but less than 9	2	21,234,428	(8,413,520)	(4,206,760)	24	69,397,866
9 or more, but less than 10	0	0	0	0	9	35,518,217
5 or more, but less than 10 (Subtotal)	20	\$222,804,731	\$53,075,556	\$2,653,778	210	\$686,094,626
Less than 10 (Grand Total)	236	\$3,496,994,580	\$502,348,084	\$2,128,594	3,627	\$11,203,827,240

More Than Half of Hospitals We Reviewed Received Excessive Outlier Payments in Each of the 4 Fiscal Years 2011 Through 2014

Of the 60 hospitals associated with the 236 cost reports with outlier payments totaling \$3.5 billion that we reconciled, 34 hospitals (57 percent) received excessive outlier payments in each of the 4 fiscal years of our audit. Further, the 34 hospitals received \$422 million (84 percent) of the \$502 million in excessive outlier payments to all 60 hospitals, as shown in Table 2 (on the next page).

Table 2: Outlier Payments, by Hospitals and Cost Reports, for the 60 Hospitals

Hospital Cost Reports With:	Number of Hospitals	Number of Cost Reports (B)	Total Outlier Payments	Excessive Outlier Payments		
				Total (D)	Average Per Cost Report (D ÷ B)	Average Per Year (D ÷ 4)
Excessive Payments in All 4 Years	34	136	\$2,064,045,303	\$421,794,872	\$3,101,433	\$105,448,718
Excessive Payments in Some Years Exceeded Underpayments in Other Years	19 ¹⁵	74	1,061,563,535	119,438,152	1,614,029	29,859,538
Underpayments in Some Years Exceeded Excessive Payments in Other Years	5 ¹⁶	18	182,801,477	(9,085,846)	(504,769)	(2,271,462)
Underpayments in All 4 Years	2	8	188,584,265	(29,799,094)	(3,724,887)	(7,449,774)
Total	60	236	\$3,496,994,580	\$502,348,084	\$2,128,594	\$125,587,020

As shown in Table 2 and elsewhere, hospitals can receive excessive outlier payments year after year by increasing their charges just enough to cause a small decrease in their previously calculated CCR that, in turn, causes a slight percentage-point decrease in the actual CCR so that reconciliation is not triggered.

THE COSTS OF RECONCILING ALL COST REPORTS WITH OUTLIERS

We estimated the potential costs to MACs, as well as the potential return on investment, of reconciling the 236 cost reports that did not meet the 10-percentage-point threshold. We contacted the 8 MACs that hold contracts for all 12 jurisdictions and requested information on

¹⁵ For 1 of the 19 hospitals, 2 cost reports for 2 years met the 10-percentage-point threshold for reconciliation; therefore, we excluded those 2 cost reports from Table 2.

¹⁶ For one of the five hospitals, two cost reports for 2 years met the 10-percentage-point threshold for reconciliation; therefore, we excluded those two cost reports from Table 2.

the estimated time and costs involved in reconciling hospital cost reports. We received responses from 7 MACs holding contracts for 10 jurisdictions.

The estimated time and cost needed to reconcile a cost report varied among MACs. The time ranged from 2 to 40 hours, depending on the complexity of the cost report. The cost of reconciliation varied from \$100 to \$180 per hour. Applying the MACs' minimum time estimate of 2 hours to reconcile a cost report to the MACs' minimum cost of \$100 per hour, we estimate the minimum cost for MACs to reconcile one cost report to be \$200. Conversely, applying the MACs' maximum time estimate of 40 hours to the maximum cost of \$180, the maximum cost for MACs to reconcile one cost report would be \$7,200. Based on these estimated cost figures, we estimate that the administrative burden on the MACs to reconcile the 236 cost reports that did not meet the 10-percentage-point threshold would be a minimum of \$47,200 and a maximum of \$1.7 million for 4 years, or a minimum of \$11,800 and a maximum of \$425,000 per year.

CONCLUSION

The outlier reconciliation process may affect a hospital's decision about whether to increase its charges. The detection and recovery of outlier overpayments through reconciliation may deter a hospital from increasing its charges so significantly that it decreases its CCR by 10 percentage points or more. However, if hospitals increase their charges without changing their CCRs by more than 10 percentage points, they can still receive more outlier payments. In addition, if hospitals increase their charges only at a lower rate than the rate of their cost increase, and if such stagnant charge increase results in less than 10 percentage point increase in their CCRs, they will remain underpaid. Of the 3,888 cost reports with outlier payments exceeding \$500,000 that we reviewed, 3,863 cost reports (99 percent) did not meet or exceed the 10-percentage-point threshold; thus, they were not reconciled and related excessive outlier payments (and outlier underpayments in certain cases) were not detected.

RECOMMENDATION

We recommend that CMS require reconciliation of all hospital cost reports with outlier payments during a cost-reporting period. If the reconciliation requirement had been in effect for the 60 hospitals in our audit, CMS would have saved approximately \$125 million per year.¹⁷

¹⁷ The actual future savings is likely significantly higher because the 60 sampled hospitals represented less than a quarter of the total outlier payments exceeding \$500,000 during the audit period. These hospitals were not selected randomly. We judgmentally selected hospitals based on their outlier payments.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendation and stated that it is evaluating the current outlier reconciliation criteria and will consider whether to propose any appropriate modifications to the outlier reconciliation policy in future rule making.

CMS's comments are included in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From fiscal years 2011 through 2014, CMS made approximately \$18,405,420,852 in outlier payments. Of this \$18,405,420,852, we reviewed \$3,496,994,980 in outlier payments to 60 hospitals. Our audit consisted of recalculating the outlier amounts based on the actual CCRs taken from the latest cost reports of these 60 hospitals. We also analyzed CCRs of 912 hospitals that received \$11,203,827,240 in outlier payments during the 4-year period.

We conducted our fieldwork from September 2016 through October 2018 at our offices in Chicago, Illinois, and St. Paul, Minnesota.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS's controls over the outlier reconciliation process;
- selected 60 hospitals by performing the following steps:
 - obtained the acute-care hospital cost-report data from the HCRIS database for 2013 cost reports (the 2013 cost report file),
 - extracted total outlier payments reported on the cost reports using the 2013 cost-report file and separated the resulting database into two groups: (1) hospitals that are located in Illinois (Illinois database) and (2) hospitals that are located outside Illinois (nation-wide database), and
 - selected 60 hospitals consisting of 30 that had received the highest outlier payments in Illinois and 30 that had received the highest outlier payments nation-wide (20 States);
- determined the potential savings from reconciling outlier payments to 60 hospitals during the 4-year period by performing the following steps:
 - obtained the latest cost-report data from the HCRIS database for the 60 hospitals for the 4-year period (240 cost reports) and calculated the actual CCRs using the cost and charge data extracted from the cost reports;

- obtained from the PC Pricer¹⁸ CCRs that CMS used for making outlier payments to the 60 hospitals during the 4-year period;
- calculated the weighted average of CCRs applied at the time of claims processing, as necessary;
- calculated the percentage-point differences between the actual CCRs based on the 240 cost reports and the corresponding weighted average of CCRs for the same cost-reporting periods, resulting in a database that had 236 cost reports with differences of less than 10 percentage points;¹⁹
- obtained claim data from CMS's mainframe for the 60 hospitals for the 4-year period;
- calculated the original outlier payments by using the CCRs obtained from the PC Pricer program and claims data to verify that our calculations produced the outlier amounts that CMS paid to the hospitals; and
- recalculated, using the actual CCRs, the outlier payment amounts of claims related to 236 cost reports that did not meet the reconciliation criteria;
- determined the percentage-point differences between the CCRs applied at the time of claims processing and the actual CCRs during the 4-year period for 912 hospitals by performing the following steps:
 - using the provider-specific files downloaded from the CMS website, we (1) created a database of CCRs applied at the time of claims processing for all hospitals during the 4-year period and (2) for each hospital in the database, calculated the weighted averages of CCRs applied at the time of claims processing every year in the 4-year period, with a resulting database of 3,626 hospitals;
 - using the cost reports downloaded from HCRIS, we:
 - created a database of hospitals that received \$500,000 or more in outlier payments every year during the 4-year period and (2) then removed 60 hospitals for which we performed outlier reconciliation and 63 hospitals for which cost-report data for CCR calculation was incomplete, resulting in a database of 912 hospitals;

¹⁸ The PC Pricer is a tool used to estimate Medicare PPS payments.

¹⁹ The remaining four cost reports had differences of 10-percentage points or more; thus we did not include them in our database.

- created a database of Medicare costs and Medicare charges based on the 3,648 cost reports of the 912 hospitals;²⁰ and
- calculated the actual CCRs based on the 3,648 cost reports; and
- o calculated the differences between the CCRs applied at the time of claim processing and the actual CCRs based on the 3,648 cost reports, resulting in a database that had 21 cost reports with differences of 10 percentage points or more and 3,627 cost reports with differences of less than 10 percentage points; and
- discussed the results of our audit with CMS officials.

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.

²⁰ 912 hospitals × 4 years = 3,648 cost reports.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Vulnerabilities Remain in Medicare Hospital Outlier Payments</i>	A-07-14-02800	9/14/2017
<i>National Government Services, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00016	9/28/2015
<i>Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 1</i>	A-07-13-02795	7/22/2015
<i>CGS Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-13-02791	5/29/2015
<i>Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 11</i>	A-07-10-02775	4/23/2015
<i>National Heritage Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00024	4/21/2015
<i>Cahaba Government Benefits Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00019	3/30/2015
<i>Novitas Solutions, Inc. (Formerly Highmark Medicare Services, Inc.), Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00023	3/27/2015
<i>First Coast Service Options, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-05-11-00022	3/27/2015
<i>National Government Services, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 8</i>	A-05-14-00046	3/16/2015
<i>Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02774	12/16/2014

Report Title	Report Number	Date Issued
<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 C: EXAMPLES OF EFFECTS OF SIGNIFICANT CHANGES IN CHARGES
OVER THE COST-TO-CHARGE RATIO**

**A SIGNIFICANT INCREASE IN CHARGES MAY DECREASE A HOSPITAL’S COST-TO-CHARGE RATIO
BY ONLY A FEW PERCENTAGE POINTS**

A hospital could dramatically increase its charges over its costs in a cost-reporting period without triggering reconciliation, as shown in Exhibit 1.

Exhibit 1: The Effect of a Significant Increase in Charges on a CCR

A hypothetical hospital reports Medicare costs of \$70 million and Medicare charges of \$373 million on its 2012 cost report, which results in a CCR of 0.188 (\$70 million ÷ \$373 million). The Medicare contractor settles this cost report as final in 2013. No other cost reports of this hospital are settled. Thus, for all claims processed for payment from this hospital in calendar year 2014, the CCR applied at the time of claim processing is 0.188. For calendar year 2014, the hospital’s costs increase 10 percent from the total in 2012, and charges increase by 30 percent from 2012. The hospital’s cost report does not meet the 10-percentage-point threshold because the percentage-point difference between the CCR applied at the time of claims processing, 0.188, and the actual CCR in 2014, 0.159, is only 2.9 percentage points. If the hospital had increased 2014 charges by 100 percent from the 2012 charges, it still would not have met the 10-percentage-point threshold because the difference between the CCR applied at the time of claims processing and the actual CCR would have been only 8.5 percentage points.

Description	Year 2012	Year 2014	
		Costs Increase 10 Percent and Charges Increase 30 Percent	Costs Increase 10 Percent and Charges Increase 100 Percent
Costs	\$70 million	\$77 million	\$77 million
Charges	\$373 million	\$485 million	\$746 million
Actual CCR	0.188	0.159	0.103
CCR Applied		0.188	0.188
Difference Between the CCR Applied and the Actual CCR		2.9 percentage points	8.5 percentage points

Neither the 30-percent increase nor the 100-percent increase in the hospital’s charges, as shown in Exhibit 1, results in a percentage-point decrease in the hospital’s CCR that would meet the 10-percentage-point threshold. Consequently, the hospital’s cost report would not be subjected to the outlier reconciliation process.

A CHANGE OF A FEW PERCENTAGE POINTS IN A HOSPITAL’S COST-TO-CHARGE RATIO COULD RESULT IN MILLIONS OF DOLLARS IN EXCESSIVE OUTLIER PAYMENTS

A hospital that has a CCR that declines just a few percentage points could receive significantly more in outlier payments that would remain undetected and unrecovered because the hospital’s cost report does not meet the threshold required for it to be reconciled. One hospital in our sample had a decrease in its CCR of 1.4 percentage points, and it received \$50,569 more in outlier payments for just one claim, as shown in Exhibit 2.

Exhibit 2: The Effect of a Change of 1.4 Percentage Points in the Cost-to-Charge Ratio on One Outlier Payment in 2013

Description	Claim Payment Based on CCR at the Time of Claims Processing	Claim Payment Based on Actual CCR	Percentage-Point Change	Increase in Outlier Payment
CCR	0.211	0.197	1.4	
Outlier Payment	\$734,043	\$683,474		\$50,569

This hospital received a total of \$6 million in excessive outlier payments in 2013. During the 4-year period, this hospital received a total of \$7 million²¹ in excessive outlier payments.

²¹ This \$7 million is the sum of \$779,000 more in 2012 outlier payments that the hospital received, \$6 million more in 2013 outlier payments that the hospital received, and \$3.5 million more in 2014 outlier payments that the hospital received, reduced by \$3.6 million less in 2011 outlier payments that the hospital received (\$7 million = \$779,000 + \$6 million + \$3.5 million - \$3.6 million).



APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: September 27, 2019

TO: Joanne Chiedi
Acting Inspector General
Office of Inspector General

FROM: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Hospitals Received Millions in Excessive Outlier Payments Because CMS Limits the Reconciliation Process (A-05-16-00060)

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 ensuring accurate payments to providers and facilities.

CMS uses a prospective payment system 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. This additional payment is designed to protect a Medicare participating hospital from large financial losses due to unusually expensive cases. In order to qualify for an outlier payment, a case must have costs above the fixed-loss outlier threshold amount, which is the dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment. 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. If 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.

In 2003, CMS set the criteria used for reconciliation of outlier payments in cases where the cost-to-charge ratio is found to be plus or minus 10 percentage points from the cost-to-charge ratio used during that time period to make outlier payments, and the total outlier payments in that cost reporting period exceeds \$500,000. Since then, CMS has developed the Fiscal Intermediary Standard System Lump Sum Utility to automatically recalculate outlier claims for reconciliation, improving the timeliness of outlier payment reconciliation. The tool reduces the administrative burden of outlier reconciliation, thereby reducing the associated processing costs.

CMS recognizes the importance of making accurate payments to hospitals and as such, CMS is reevaluating the current outlier payment reconciliation criteria.

OIG's recommendation and CMS' response are below.

OIG Recommendation

We recommend that CMS require reconciliation of all hospital cost reports with outlier payments in a cost-reporting period.

CMS Response

CMS concurs with this recommendation. As stated above, CMS is reevaluating the current outlier payment reconciliation criteria and will consider whether to propose any appropriate modifications to the outlier reconciliation policy in future rulemaking.