Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORIDIAN HEALTHCARE SOLUTIONS REOPENED AND CORRECTED COST REPORT FINAL SETTLEMENTS TO COLLECT $11 MILLION IN NET OVERPAYMENTS THAT HAD BEEN MADE TO MEDICARE PROVIDERS

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

Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers

Why OIG Did This Audit

Medicare-certified providers are required to submit an annual cost report to their Medicare administrative contractor (MAC). Cost reports are financial documents that convey the provider's costs associated with providing services to people enrolled in Medicare. A MAC can decide to audit a provider's cost report before bringing it to final settlement. If there is an error made in the final settlement, the MAC can reopen and adjust the cost report final settlement to correct the error.

We performed this audit to determine whether one MAC, Noridian Healthcare Solutions (Noridian), reopened and corrected cost report final settlements because of audit errors.

Our objectives were to determine: (1) how many audited cost reports Noridian reopened to correct the final settlements and (2) whether any of the audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian.

How OIG Did This Audit

We obtained information for audited cost reports ending in fiscal years 2016 and 2017 and determined whether they had been reopened. We obtained workpapers, audit adjustments, and final settlement summaries. After removing cost reports that were outside of our scope, we reviewed 12 cost reports for this audit.

What OIG Found

We determined that Noridian reopened 141 audited cost reports to correct the final settlements. Of these, 84 cost reports were reopened based on new information or at the request of the Centers for Medicare & Medicaid Services (CMS). In addition, 45 cost reports were not related to our objectives; we excluded these from our review. For our second objective, of the remaining 12 audited cost reports that Noridian reopened and that we reviewed, Noridian's audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian.

These 12 cost reports required reopening because Noridian's auditors and supervisors required additional education on applicable criteria and audit requirements, because Noridian's procedures for multiple levels of review did not detect incorrect audit adjustments, and because of time constraints on Noridian's audits. The reopened cost reports resulted in revised final settlements to providers totaling almost $11.3 million in net overpayments.

What OIG Recommends and Noridian Comments

We recommend that Noridian: (1) develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements; (2) develop and implement procedures to allow enough time for adequate auditor and supervisory review of audit documents and related actions; and (3) develop and implement enhanced procedures so that supervisors and higher-level reviewers are better qualified to detect incorrect audit adjustments.

Noridian concurred with our recommendations and provided information on actions that it had taken or planned to take to address them. Noridian stated that the number of reopenings related to errors made up just over 4 percent of the audits that it completed during fiscal years 2016 and 2017. Noridian said that it would collaborate with CMS's training contractor to develop new training curriculum and described other measures it had taken with respect to internal training. Noridian also referred to ongoing reorganization of its staff, to include the implementation of a new staff position to complete first-level supervisory review and to coach and mentor staff. In addition, Noridian stated that it had implemented a quality review process and that it was reviewing its standard operating procedures and conducting training on those procedures.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare-certified institutional providers including hospitals, skilled nursing facilities, and home health agencies, among others, are required to submit an annual cost report to their Medicare administrative contractor (MAC).[1] Cost reports are financial documents that convey the provider's costs associated with providing services to people enrolled in Medicare and are used by MACs to determine the final amount of Medicare program reimbursement due providers for their cost reporting period (*i.e.*, accounting year).

A MAC, as part of its Medicare Integrity Program activities, can audit a provider's cost report after performing a mandatory desk review to further verify compliance with the law, regulations, and Medicare manual instructions relating to the determination of reimbursement amounts.[2] These amounts include graduate medical education (GME) payments, indirect medical education (IME) payments, disproportionate share hospital (DSH) payments, payments associated with bad debts, and certain other amounts, as well as cost-reimbursed items, such as reasonable costs claimed by cancer hospitals or critical access hospitals.[3] At the conclusion of the MAC's audit, the MAC issues a Notice of Program Reimbursement (NPR) to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to Medicare. If there is an error made in the final settlement, the cost report final settlement can be reopened and adjusted to correct for the error.[4]

Although some cost reports that have been audited and settled are later reopened to correct the final settlement, the MACs maintain supporting documents for the cost reports that they reopen and for the reasons for the reopenings. These supporting documents include information related to the monetary adjustments to correct the final settlements. MACs submit cost report-related information to the Centers for Medicare & Medicaid Services (CMS).

We performed this audit to determine whether Noridian Healthcare Solutions (Noridian), which currently has multiple MAC jurisdictions covering 13 States and 3 Territories, reopened and corrected cost report final settlements because of audit errors.

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[1] Social Security Act (the Act) § 1815(a); 42 CFR § 405.1801(b)(1); 42 CFR § 413.24(f).

[2] The Medicare Integrity Program is established under the provisions of the Act § 1893, which describes program integrity activities to prevent or detect improper payments.

[3] GME payments are meant to reimburse providers for the direct cost of training medical students. IME payments are meant to reimburse providers for the indirect cost of training medical students. DSH payments are meant to reimburse hospitals for the cost of provided care for low-income patients. These and other payments constitute the "reimbursable amounts" that are the focus of this report.

[4] We refer to the reopening of cost report final settlements as the reopening of cost reports throughout the remainder of the report.

OBJECTIVES

Our objectives were to determine: (1) how many audited cost reports Noridian reopened to correct the final settlements and (2) whether any of the audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian.

BACKGROUND

Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage for extended care services for patients after discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of therapy services. CMS administers the Medicare program and contracts with MACs to, among other things, process and pay claims submitted by health care providers.

Medicare Cost Reports

Certain institutional providers such as hospitals, skilled nursing facilities, home health agencies, renal dialysis centers, hospices, rural health clinics, community mental health centers, federally qualified health centers, and organ procurement organizations are required to submit annual cost reports to their MAC. CMS uses the financial and statistical data reported in the cost reports to set Medicare payment rates and calculate reimbursements for provider spending on medical education, uncompensated care, low-income patients, and high-cost Medicare cases. The cost report contains a series of worksheets with information on facility characteristics, health care utilization, employee salary and wage data, facility costs and charges, and Medicare settlement data.

Providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the MAC performs a tentative settlement, then performs a desk review of the cost report and conducts an audit, as appropriate, before final settlement.[5]

Medicare Administrative Contractor Cost Report Reviews

MACs serve as the primary operational contact between the Medicare fee-for-service program and the health care providers enrolled in the program. MACs perform many administrative activities, including desk reviews and audits of cost reports.

[5] 42 CFR § 413.64(f)(2); *Provider Reimbursement Manual*, CMS Pub. 15-1, Part 1, § 2408.2; *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.

MACs must conduct desk reviews of cost reports for all providers that file a Medicare cost report, with the exception of cost reports for hospices and for providers that have low or no Medicare utilization. A desk review is an analysis of the provider's cost report to evaluate its adequacy and completeness and determine the accuracy and reasonableness of the data contained in the cost report. This process does not include detailed verification and is designed to identify issues that may warrant additional review. The purpose of the desk review is to determine whether the cost report can be settled without an audit or whether an audit is necessary.[6] In contrast, an audit is an examination of financial transactions that tests the provider's compliance with the law, regulations, and Medicare manual instructions.

In selecting cost reports to audit, the MAC uses its professional judgment in determining which providers represent the greatest risk of incorrect payment.[7] MACs perform audits in compliance with the Government Auditing Standards issued by the Comptroller General of the United States and use desk reviews and empirical knowledge of providers to define audit objectives and the scope and methodology to achieve those objectives.[8] If the MAC finds that claimed amounts in the cost report are not in accordance with the law, regulations, or Medicare manual instructions, it can create an audit adjustment to ensure that the cost report complies with those requirements.[9] All audit work performed is subject to supervisory review to ensure audit quality.[10] At the conclusion of the audit, the MAC then issues an NPR to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to the Medicare program.[11]

Cost Report Reopenings

A cost report final settlement may be reopened at the request of the provider or on the MAC's own initiative within 3 years of the date of the NPR to reexamine and adjust the final determination of the amount of total reimbursement due the provider (42 CFR § 405.1885).[12] The decision by the MAC to reopen a settled cost report generally depends on whether new

[6] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.1.

[7] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 40.

[8] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 30.1, 50.1, and 80.

[9] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 60.11 and 70.4.

[10] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 60.13.

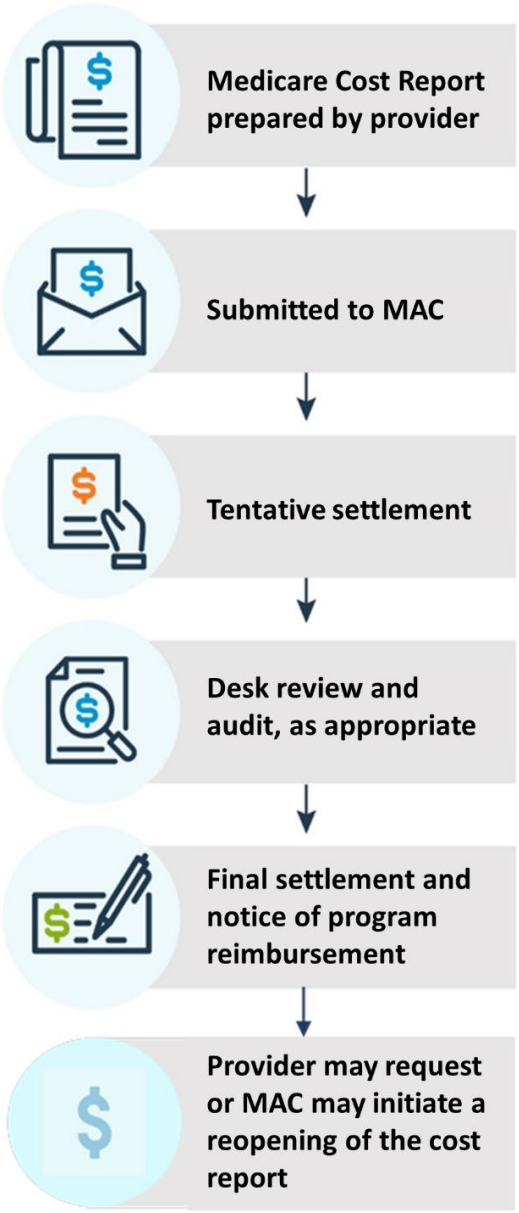
[11] For example, a hypothetical provider claims a total reimbursement of $100,000,000 on its cost report and the provider has been paid throughout the year for claims and with other payments totaling $95,000,000. The MAC's auditor creates an audit adjustment to the worksheets of $(2,000,000) to ensure that the cost report complies with Medicare regulations and Medicare manual instructions. Accordingly, the NPR would specify that a $3,000,000 payment is due the provider at the final settlement.

[12] A MAC may reopen and revise a final settlement at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.

and material evidence has been submitted by the provider, an error was made during the final settlement process, or the settled cost report is found to be inconsistent with the law, regulations, and manual instructions (*Provider Reimbursement Manual*, part I, § 2931.2).

The figure depicts the Medicare cost report submission, review, settlement (tentative and final), and reopening process.

Figure: Medicare Cost Report Process



HOW WE CONDUCTED THIS AUDIT

We obtained information regarding 287 audited cost reports ending in fiscal years 2016 and 2017 for Noridian's Parts A and B MAC jurisdictions, and determined whether they had been reopened. Of these 287 audited cost reports, Noridian had reopened 141 of them. For those 141 cost reports that had been reopened and upon which our first objective focused, we obtained workpapers, audit adjustments, and final settlement summaries to identify the reasons the audits had been reopened and the effects of the audit adjustments. Of the 141 reopened cost reports, we did not review 84 cost reports that had been reopened and settled only for reasons involving Medicare (DSH) payments for new Medicaid patient days or new patient days for both Medicare and Supplemental Security Income (SSI).[13] These 84 cost reports also included those whose reopenings had been directed by CMS. This left us with 57 cost reports for further review.

After further review of the remaining 57 cost reports that Noridian had reopened, we identified 45 cost reports that Noridian reopened either because: (1) Noridian had received new information, (2) the reopened cost reports had not yet resulted in corrected final settlements, or (3) errors on the parts of providers had come to Noridian's attention. This left 12 audited cost reports, which were reopened to correct final settlements that contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions, remaining for further review.[14] Our second objective focused on these 12 audited cost reports.

From the remaining 12 audited cost reports that were reopened to correct the final settlements, we analyzed whether the provider requested a reopening or Noridian initiated the reopening, the reasons for the reopening, and the effect of the corrected final settlement. When applicable, Noridian officials furnished, and we reviewed, a description of the reasons the audited cost reports were reopened to correct final settlements that contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions.

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.

[13] We considered the reasons for these reopened cost reports to constitute new and material evidence that was not within our scope. The term "new Medicaid patient days" refers to patient days for individuals who were eligible for Medicaid. The other category of new patient days described here consists of patient days for individuals who were eligible for both Medicare and SSI. We treated these patient days as new because they were claimed for the first time in the reopened cost reports; therefore, they had no bearing on Noridian's quality and performance on its audit of the initial cost reports.

[14] Noridian defined an obvious error as an error that occurred to the initial determination or decision based on: (1) incorrect evidence on file on which the determination was based or (2) any evidence of record anywhere in the contractor's Medicare file or in CMS files at the time such initial determination or decision was made. Typically, an obvious error is an occurrence such as a mathematical error or a data entry error.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

We determined that Noridian reopened 141 of 287 audited cost reports to correct the final settlements. Of these, we found that 12 were reopened to correct final settlements that contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions. Of the 141 reopened cost reports, 84 were reopened based on new information or at CMS's request. In addition, 45 cost reports were not related to our objectives because they involved new information, had not yet been brought to a corrected final settlement, or had errors caused by providers (rather than Noridian). We excluded these 45 cost reports from our review. Of the 12 audited cost reports pertaining to our second objective, Noridian reopened 11 cost reports because its final settlements contained obvious errors and 1 cost report because its final settlement was inconsistent with the law, regulations, or Medicare manual instructions. We determined that the errors or inconsistencies associated with Noridian's audits of these 12 cost reports were caused by Noridian.

These 12 audited cost reports required reopening because of human errors by Noridian personnel. Some of these errors involved misclassifying, misrecording, or miscalculating audit adjustments. Other errors involved Noridian employees misunderstanding applicable requirements when making audit adjustments or not performing required audit procedures. Noridian officials stated that auditors and supervisors required additional education on the criteria and audit requirements applicable to the reimbursement of amounts or reasonable costs being claimed (e.g., GME, IME, DSH, and other payments; footnote 3). Additionally, Noridian's procedures for multiple levels of review by supervisors did not detect the incorrect audit adjustments, and according to Noridian officials, in one instance auditors and supervisors did not perform an adequate review of audit adjustments because of time constraints.

As a result of these errors and shortcomings in education of staff, for these 12 cost reports, the reopened cost reports resulted in corrected final settlements to providers totaling $11,276,361 in net overpayments (which consisted of $12,091,105 in overpayments and $814,744 in underpayments). Moreover, although an analysis of time delays was not part of our methodology for this audit, the risk exists that delays in the finalization of audited cost reports could prevent some Medicare funds from being expended in the most efficient and effective ways.

DETERMINATION OF COST REPORTS THAT NORIDIAN REOPENED TO CORRECT THE FINAL SETTLEMENTS

We determined that Noridian reopened 141 of 287 audited cost reports to correct the final settlements. Of the 141 reopened cost reports, 84 were not related to our objectives because they were reopened based on new information or at CMS's request. We excluded these 84 cost reports from our review for our second objective. In addition, 45 cost reports were not related to our objectives because they involved new information, had not yet been brought to a

corrected final settlement, or had errors caused by providers (rather than Noridian). We excluded these 45 cost reports from our review for our second objective.

ELEVEN REOPENED COST REPORTS INVOLVED OBVIOUS ERRORS BY NORIDIAN

Of the 12 audited cost reports that Noridian reopened to correct final settlements that contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions, 11 cost reports were reopened to correct the audit adjustments for obvious errors on Noridian's part. Below are examples of the reopening adjustments for obvious errors in two of the cost reports' final settlements. Appendix B provides the details about the audit adjustment errors, including Noridian's descriptions of why the errors occurred, information on specific Medicare requirements, and identification of who detected the error.

According to Noridian, for one cost report, one provider requested a reopening of the final settled cost report because Noridian's audit mistakenly reclassified Medicare charges of $58,106 from one clinic to another, which resulted in a calculated cost-to-charge ratio of 748.00 for that provider. After Noridian reopened this cost report to correct the reclassification of Medicare charges, the cost-to-charge ratio for this provider was 1.78. Reopening adjustments of the final settlement corrected the overpayment of $6,257,113 that had been paid to this provider.[15]

According to Noridian, for another cost report, another provider requested a reopening of the final settlement to correct four occurrences in which Noridian's audit had made mistakes. Specifically, Noridian's audit had incorrectly:

- changed the hospital status, which resulted in an increase of the provider's DSH percentage from 19.72 percent to 35 percent, and consequently an overpayment to the provider of $3,562,541;[16]

- recorded 25 (instead of 26, the correct number) bi-weekly payments received by the provider throughout the year, which resulted in an overpayment to the provider of $901,012;

- recorded an additional 5.81 full-time equivalent (FTE) employees in the cost report for GME reimbursement, which resulted in an overpayment of $88,022 to the provider; and

[15] The cost-to-charge ratio is the ratio between a hospital's expenses and what it charges to all payers, such as Medicare, private insurance, or the patient.

[16] With respect to providers' reimbursement of DSH payments (footnote 3) on their cost reports, Noridian changed the hospital status from reimbursing based on its percentage of Medicaid and both Medicare and SSI days (19.72 percent) to reimbursing based on a flat percentage (35 percent). The flat percentage was based on the hospital receiving more than 30 percent of its total inpatient care revenues from State and local governments for indigent care furnished to patients not covered by Medicare or Medicaid.

- understated Medicare Advantage days associated with certain programs, which resulted in an underpayment of $4,721 to the provider.[17]

Reopening adjustments to the audited cost report final settlement corrected these errors and thus corrected the overall overpayment of $4,546,854 that Noridian had made to this provider.

Additional details (descriptions of and reasons for these errors, and appliable requirements) on these 11 cost reports appear in Appendix B.

These 11 audited cost reports required reopening because of human errors by Noridian personnel. Some of these errors involved misclassifying, misrecording, or miscalculating audit adjustments. Other errors involved Noridian employees misunderstanding applicable requirements when making audit adjustments or not performing required audit procedures. Noridian officials stated that these errors occurred because: (1) auditors and supervisors required additional education and did not always understand or were unaware of criteria and audit requirements applicable to the reimbursement of amounts or reasonable costs being claimed (e.g., GME, IME, DSH, and other payments; footnote 3); (2) Noridian's procedures for review by supervisors and higher-level reviewers such as managers, directors, and the quality assurance department did not detect the incorrect audit adjustments; and (3) in one instance, auditors and supervisors did not perform an adequate review of audit adjustments because of time constraints.

NORIDIAN'S FINAL SETTLEMENT OF ONE REOPENED COST REPORT WAS INCONSISTENT WITH THE LAW, REGULATIONS, OR MEDICARE MANUAL INSTRUCTIONS

Of the 12 audited cost reports that Noridian reopened and that we reviewed, 1 cost report was reopened to correct the audit adjustment, which was inconsistent with the law, regulations, or Medicare manual instructions.

According to Noridian officials, Noridian's audit did not recognize 2.76 FTE residents at a federally Qualified Health Center as allowable, which resulted in $303,630 in underpayments to the provider. This error occurred because the auditor and supervisor did not understand or were unaware of the applicable criteria (detailed in Appendix B).

REOPENED COST REPORTS RESULTED IN CORRECTED FINAL SETTLEMENTS

For the 12 cost reports we audited, the reopened cost reports resulted in corrected final settlements to providers totaling $11,276,361 in net overpayments (which consisted of $12,091,105 in overpayments and $814,744 in underpayments).

[17] The term "Medicare Advantage days" refers to patient days associated with services to beneficiaries that were covered by the Medicare Advantage (Part C) program.

RECOMMENDATIONS

We recommend that Noridian Healthcare Solutions:

- develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements;

- develop and implement procedures to allow enough time for adequate auditor and supervisory review of audit adjustments and related actions; and

- develop and implement enhanced procedures so that supervisors and higher-level reviewers are better qualified to detect incorrect audit adjustments.

NORIDIAN COMMENTS

In written comments on our draft report, Noridian concurred with our recommendations and provided information on actions that it had taken or planned to take to address them. Noridian stated that it is responsible for the "accurate processing of over 5,000 cost reports submitted annually" and added that "the number of reopenings related to errors make up just over 4% of the audits completed by Noridian during the fiscal years 2016 and 2017." Noridian also said that it agreed with our "overall assessment that improvements should be undertaken to reduce and or eliminate the errors resulting in incorrect payments made to providers."

For our first recommendation, Noridian stated that it would ensure that "adequate and timely feedback is provided to the staff involved in the review of these files" and added that it would collaborate with CMS's training contractor in the development of new training curriculum. Noridian also described measures it had taken since the completion of our audit work to establish a "robust internal training program," which among other things would highlight issues noted at quality review and issues identified by external reviews. For our second recommendation, Noridian referred to an ongoing, multi-phase reorganization of its staff structure "to streamline the training, align expectations, and optimize efficiency." Noridian also said that one aspect of this initiative was the implementation of a new staff position, whose "primary responsibilities include completion of the first level supervisory review and the ongoing coaching and mentoring of audit staff." For our third recommendation, Noridian stated that it had "implemented a pre-NPR quality review process" to quality-review cost report audits "prior to finalization to mitigate errors resulting in erroneous payments to providers." Noridian added that it was reviewing its standard operating procedures and conducting additional training on these procedures.

Noridian's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We obtained information regarding 287 audited cost reports ending in fiscal years 2016 and 2017 for Noridian's Parts A and B MAC jurisdictions, and determined whether they had been reopened. Of these 287 audited cost reports, Noridian had reopened 141 of them. Of the 141 reopened cost reports upon which our first objective focused, we did not review 84 cost reports because they had been reopened and settled based on new and material evidence or at the direction of CMS (footnote 13). The cost reports that had been reopened for new and material evidence were not within the scope of our audit because the providers claimed new patient days for the first time in the reopened cost reports; therefore, they had no bearing on the quality and performance of Noridian's audits of the initial cost reports. Similarly, we excluded the cost reports that Noridian had reopened at CMS's direction from our audit scope because they were not related to the quality and performance of Noridian's audits. The removals of these cost reports from our scope left us with 57 cost reports for further review.

After further review of the remaining 57 cost reports that Noridian had reopened, we identified 45 cost reports that Noridian reopened for reasons we discuss later in this Appendix. The removal of these 45 cost reports left 12 audited cost reports, which were reopened to correct final settlements that contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions, remaining for further review. Our second objective focused on these 12 audited cost reports.

We assessed internal controls necessary to satisfy the audit objective. In particular, we gained an understanding of Noridian's policies and procedures regarding multiple levels of supervisory review before and after the final settlement of cost reports, and we reviewed the results of our supervisory review analysis to determine whether one or more levels of supervisory review performed by Noridian were effective to detect errors in the audited cost reports that had resulted in incorrect final settlements.

We performed audit work from April 2022 to September 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and Medicare manual instructions;

- obtained and reviewed cost reports, workpapers, final settlement worksheets, and provider reopening requests from Noridian related to the final settlements and subsequent reopenings of audited cost reports for fiscal years 2016 and 2017;

- quantified both the number of cost report reopenings and the effect of the reopened and corrected settlements (exclusive of the 84 cost reports that were reopened based on new information involving DSH adjustments for new Medicaid and SSI days, other reopenings related to new and material evidence, and CMS-directed reopenings (footnote 13));

- removed from our scope 45 cost reports that Noridian had reopened because the cost reports:

    - involved new bad debt and other information that providers had claimed at the cost report reopenings (25 cost reports, for which Noridian's audits resulted in the identification of a total of $4,483,266 in underpayments to the providers);

    - had been reopened but had not resulted in corrected final settlements on Noridian's part before our January 2023 exit conference with Noridian officials (15 cost reports); and

    - had been reopened after errors on the parts of providers had come to Noridian's attention (5 cost reports, for which Noridian's audits resulted in the identification of a total of $642,636 in underpayments to the providers);

- for the remaining 12 audited cost reports (upon which our second objective focused), obtained and reviewed the descriptions and causes of reopened final settlements as provided to us by Noridian;

- obtained and reviewed Noridian's policies and procedures about the reopening process and interviewed Noridian personnel about the audit and reopening process;

- determined the adequacy of one or more levels of review by Noridian to detect errors in the audited cost reports; and

- discussed the results of our audit with Noridian officials in January 2023.

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: AUDIT ERROR DETAILS

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Noridian on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
1	Noridian committed a clerical error by recording outpatient charges to the wrong clinic, which significantly increased the cost-to-charge ratio.	Supervisor did not detect the incorrect audit adjustments.	Providers receiving payment based on reimbursable costs must provide adequate cost data (42 CFR § 413.24). Charges are the regular rates established by the provider for services rendered to people with Medicare and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient (CMS Pub. No. 15-1, § 2302.6).	Provider	$6,257,113
2	Noridian: (1) changed the hospital's status, which increased the DSH payment percentage; (2) used the incorrect number of FTE residents working in the hospital when it calculated the resident cap for the cost reporting	The supervisor did not detect the incorrect audit adjustments, and the auditor and supervisor did not understand or were unaware of applicable criteria or review requirements.	Providers receiving payment based on reimbursable costs must provide adequate cost data (43 CFR § 413.24). Cost information developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to people with Medicare (CMS Pub. No. 15-1 § 2304). Hospitals are paid for the costs of approved GME programs (42 CFR § 413.75).	Provider	4,546,854

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Noridian on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
	period; (3) excluded biweekly payments; and (4) calculated Nursing and Allied Health Education (NAHE) managed care payment that did not include Medicare Advantage days.		CMS makes an additional payment to hospitals for indirect medical education costs (42 CFR § 412.105). A hospital that operates and receives payment for a NAHE program may receive an additional payment amount associated with Medicare Advantage utilization (42 CFR § 413.87).		
3	Noridian incorrectly included an Electronic Health Record (EHR) incentive payment even though the provider was not on CMS's list of hospitals successfully demonstrating a meaningful use of EHRs.	The supervisor did not detect the incorrect audit adjustments.	Medicare will make an incentive payment to eligible hospitals that are meaningful EHR users (the Act § 1886(n)).	Noridian	885,228
4	Noridian incorrectly reported the allowable DSH percentage because it did not report the	The supervisor did not detect the incorrect audit adjustments.	Hospitals that serve a disproportionate share of low-income patients receive special treatment. (42 CFR § 412.106)	Provider	197,971

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Noridian on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
	allowable DSH percentage in all columns of the cost report.				
5	Noridian: (1) used an incorrect error rate to estimate allowable bad debts and (2) allowed an NAHE managed care adjustment when the provider was not eligible for the payment.	An auditor and supervisor did not understand or were unaware of applicable criteria or review requirements.	Allowable bad debts are reimbursable under Medicare (CMS Pub. No. 15-1 § 300). A hospital that operates and receives payment for an NAHE program may receive an additional payment amount associated with Medicare Advantage utilization (42 CFR § 413.87).	Noridian	157,251
6	Noridian (1) miscalculated the allowable DSH percentage due to an error in the SSI percentage and (2) incorrectly reported diagnosis-related group (DRG) and outlier payments without recognizing the provider changed its	The auditor and supervisor had limited time to perform an adequate review.	A hospital's disproportionate share calculation is determined by the number of patient days for patients entitled to Medicare Part A and SSI for the period divided by the number of discharge days for Medicare Part A patients, including those enrolled in Medicare Advantage (42 CFR § 412.106). Enter the correct DRG and outlier payments when a hospital changes SCH status during the cost reporting	Noridian	25,559

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Noridian on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
	status to a Sole Community Hospital (SCH) during the cost reporting period.		period (CMS Pub. No. 15-2 § 4030.1).		
7	Noridian used an incorrect error rate to estimate allowable bad debts.	The supervisor did not detect the incorrect audit adjustment.	Allowable bad debts attributable to the deductibles and coinsurance amounts are reimbursable under Medicare (42 CFR § 413.89).	Noridian	20,960
8	Noridian incorrectly included an EHR incentive payment when the provider was not on CMS's list of hospitals successfully demonstrating meaningful use of EHRs. Noridian also incorrectly included EHR data from the wrong year.	The supervisor did not detect the incorrect audit adjustment.	Medicare will make an incentive payment to eligible hospitals that are meaningful EHR users (the Act § 1886(n)).	Noridian	169
9	Noridian: (1) did not review the physician salary cap and (2) incorrectly reported prior-	The auditor and supervisor did not understand or were unaware of	CMS establishes reasonable compensation equivalent limits on the amount of compensation paid to physicians (a physician salary cap) by providers by considering average	Noridian	(16,889)

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Noridian on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
	year, weighted GME FTEs (not in an initial residency period).	applicable criteria or review requirements.	physician incomes by specialty using the best available data (42 CFR § 415.70(b)). The weighted average per resident amount is established by first determining: (1) each hospital's single per-resident amount and (2) an average of all hospitals' standardized per-resident amounts using a base year geographic adjustment factor (42 CFR § 413.86). Then, CMS uses these results to calculate an average of all hospitals' standardized per-resident amounts.		
10	Noridian adjusted the reported percentage of low-income patients who received SSI to the hospital instead of the subprovider.	Supervisors did not detect the incorrect audit adjustment.	Worksheet E-3, Part III, of the cost report is used to calculate Medicare reimbursement settlement for hospitals and subproviders. Use a separate copy of Worksheet E-3, Part III for each of these reporting situations. (CMS Pub. No. 15-2 § 4033.3).	Noridian	(27,547)
11	Noridian reported incorrect allowable bad debts because of a mis-understanding	The auditor and supervisor did not understand or were unaware of	Allowable bad debts attributable to the deductibles and coinsurance amounts are reimbursable under Medicare (42 CFR § 413.89).	Provider	(466,678)

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Noridian on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
	about the validity of crossover claims (those patient claims with both Medicare and Medicaid benefits) with certain codes.	applicable criteria or review requirements.			
12	Noridian did not recognize 2.76 FTE residents at a federally Qualified Health Center as allowable to a non-provider site.	The auditor and supervisor did not understand or were unaware of applicable criteria or review requirements.	The time residents spend in non-provider settings, such as freestanding clinics, nursing homes, and physician offices, in connection with approved programs, may be included when determining the number of FTE residents in the calculation of a hospital's resident count if: (1) the resident spends his or her time in patient care activities or the resident spends his or her time engaged in certain non-patient care activities in a nonprovider setting that is primarily engaged in furnishing patient care activities; and (2) the hospital(s) incur the reasonable costs of the salaries and fringe benefits associated with care of the resident during the time the resident spends in the non-	Provider	(303,630)

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Noridian on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			provider setting (42 CFR § 413.78(g)).		

* As reported by Noridian.

† If the provider detected the error, the provider requested that Noridian reopen the cost report final settlement. If Noridian detected the error, Noridian initiated the reopening of the cost report final settlement.

‡ Noridian corrected overpayments/underpayments during the reopening of the final settlement.

APPENDIX C: NORIDIAN COMMENTS

900 42nd Street S.
Fargo, ND 58103

October 18, 2023

Patricia Wheeler, Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region IX
1100 Commerce Street Room 632
Dallas, TX 75242

Report Number: A-06-22-05000

Dear Ms. Wheeler:

Noridian Healthcare Solutions, LLC (Noridian) appreciates the opportunity to review and offer comments on the Office of Inspector General's (OIG) draft report entitled: *Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements to Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers.* As noted in the report, Noridian is the Medicare contractor for multiple jurisdictions covering 13 states and three territories. As such, Noridian assumes responsibility for the accurate processing of over 5,000 cost reports submitted annually in Jurisdictions E & F and will take all appropriate measures to prevent errors resulting in erroneous payments to providers and protect the integrity of the Medicare Trust Fund. In addition to taking the corrective actions described below relative to Medicare cost report audits, Noridian is dedicated to continuously monitoring and improving its processes and collaborating with other Medicare Administrative Contractors and CMS subcontractors, such as Myers & Stauffer, the organization contracted by CMS to administer the QASP, IRIS, Training & Support (QITS) contract. Although the number of reopenings related to errors make up just over 4% of the audits completed by Noridian during the fiscal years 2016 and 2017, we do agree with the OIG's overall assessment that improvements should be undertaken to reduce and or eliminate the errors resulting in incorrect payments made to providers.

The OIG's recommendations and Noridian's responses are below.

OIG Recommendation 1:

Develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements.

Noridian Response:

Noridian concurs with the recommendation to develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements. Noridian will ensure adequate and timely feedback is provided to the staff involved in the review of these files for understanding of the issues noted and update our current documentation. Noridian will continue to conduct internal training, and both develop and collaborate with the CMS QITS contractor in the development of new training curriculum. Since the time when these audits were completed Noridian has established a robust internal training program. This includes a dedicated staff that works closely with the Noridian Talent Development Team to create curriculum to facilitate the ongoing training of our audit and supervisor staffs. These trainings include courses developed by our Quality Review team highlighting issues that are noted at quality review as well as issues identified by external reviews such as QASP.

OIG Recommendation 2:

Develop and implement procedures to allow enough time for adequate auditor and supervisory review of audit adjustments and related actions.

Noridian Response:

Noridian concurs with this recommendation to allow enough time for adequate auditor and supervisory reviews to occur. Noridian would like to note we have been actively working through reorganization of the overall team structure for resource management. Noridian has moved the audit staffing by like position to streamline the training, align expectations, and optimize efficiency. On July 10, 2023, Phase I of this initiative was implemented moving all Auditor I staff into a team, who completes the least complex of the audit workload. Phase II is currently underway to align Auditor II and Senior positions to handle the more complex audit workload. Additionally, a new role titled Provider Audit Technical Reviewer, is being implemented. This role's primary responsibilities include completion of the first level supervisory review and the ongoing coaching and mentoring of audit staff. This removes the process from the Provider Audit Supervisors' purview to solely focus on aspects of leadership for the team.

OIG Recommendation 3:

Develop and implement enhanced procedures so that supervisors and higher-level reviewers are better qualified to detect incorrect audit adjustments.

Noridian Response:

Noridian concurs with this recommendation to enhance procedures to allow for additional review time and improve the qualifications of staff that complete the audit, the supervisory and quality review processes. Since the NPR dates of the audits were reviewed Noridian has implemented a pre-NPR quality review process. Cost report audits are quality reviewed prior to finalization to mitigate errors resulting in erroneous payments to providers. Noridian Provider Audit Quality SOPs are undergoing review to ensure processes are further detailed and additional training on these procedures is occurring. This is done through trainings conducted at staff meetings and through courses developed by our training staff in collaboration with our Quality team.

In summary, Noridian is aware of the concerns outlined in this draft report and is taking steps to address those concerns. We appreciate the opportunity to comment on this report and the recommendations. Should you have any additional questions on this response and Noridian's actions, please contact Senior Vice President Customer Relations, Cathy Benoit, JE VP Project Manager, Becky Gunderson, or JF VP Project Manager, Nancy Kaspari.

Sincerely,

Jon Bogenreif
President and Chief Executive Officer
Noridian

CC: Mary Ahn, CMS
Linda Tran, CMS
Lucretia Knight, CMS
Cathy Benoit, SVP Customer Relations, Noridian
Troy Aswege, SVP Operations, Noridian
Becky Gunderson, JE VP Project Management, Noridian
Nancy Kaspari, JF VP Project Management, Noridian
Becky Kuznia, VP Audit Reimbursement & Recoupment, Noridian

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