Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION DID NOT ALWAYS REFER MEDICARE COST REPORTS AND RECONCILE OUTLIER PAYMENTS

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EXECUTIVE SUMMARY

Wisconsin Physicians Service Insurance Corporation (WPS) did not always* refer *cost reports whose outlier payments qualified for reconciliation to the Centers for Medicare & Medicaid Services. The net financial impact of these unreferred cost reports was approximately $51,000 that should be recouped from health care providers and returned to Medicare. In addition, WPS did not always* reconcile *the outlier payments associated with cost reports whose outlier payments qualified for reconciliation.

WHY WE DID THIS REVIEW

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

This review is one of a series of reviews to determine whether Medicare contractors had (1) referred the cost reports that qualified for reconciliation and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. One such contractor, Wisconsin Physicians Service Insurance Corporation (WPS), has been since 2007 the Medicare contractor for some legacy providers (that is, health care providers who were working with other fiscal intermediaries and carriers before the initiation of Medicare contracting reform) and for Jurisdiction 5, which comprises Iowa, Kansas, Missouri, and Nebraska.

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

BACKGROUND

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

Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses due to unusually high-cost cases. Medicare contractors calculate outlier payments on the basis of claim submissions made by hospitals and by using hospital-specific cost-to-charge ratios. Medicare contractors review cost reports that hospitals have submitted, make any necessary adjustments, and determine whether payment is owed to Medicare or to the hospital. In general, a settled cost

report may be reopened by the Medicare contractor no more than 3 years after the date of the final settlement of that cost report. We refer to this as the 3-year reopening limit.

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether WPS had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.

WHAT WE FOUND

Of 65 cost reports with outlier payments that qualified for reconciliation, WPS referred 61 cost reports to CMS in accordance with Federal guidelines. However, WPS did not refer four cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. We calculated that, as of December 31, 2011, the difference between (1) the outlier payments associated with two of these four cost reports and (2) the recalculated outlier payments totaled at least $1,819,098. We refer to this difference as financial impact. We also calculated that $1,768,149 was due from Medicare to providers for the other two cost reports of the four that should have been referred to CMS for reconciliation. The net financial impact of the outlier payments associated with these four unreferred cost reports was therefore at least $50,949 that was due to Medicare.

Of the 61 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, WPS had reconciled the outlier payments associated with 42 cost reports by December 31, 2011. However, WPS had not reconciled the outlier payments associated with the remaining 19 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 9 of the 19 cost reports that were referred but not reconciled was at least $11,517,478. We also calculated that $5,823,345 was due from Medicare to providers for 10 of the 19 cost reports that were referred but not reconciled. The net financial impact of the outlier payments associated with these 19 cost reports that were referred but not reconciled was therefore at least $5,694,133 that was due to Medicare.

WHAT WE RECOMMEND

We recommend that WPS:

- review the 4 cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation but were not; take appropriate actions to refer these cost reports; and request CMS approval to:
    - recoup $1,819,098 in funds and associated interest from health care providers (2 cost reports) and refund that amount to the Federal Government and
    - return $1,768,149 in funds and associated interest from Medicare to providers (2 cost reports);

- review the 19 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:

    - reconcile the $11,517,478 in associated outlier payments due to the Federal Government (9 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and

    - reconcile the $5,823,345 in associated outlier payments due from Medicare to providers (10 cost reports), finalize these cost reports, and return the funds to the providers;

- strengthen control procedures to ensure that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;

- strengthen policies and procedures to ensure that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and

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

AUDITEE COMMENTS AND OUR RESPONSE

In written comments to our draft report, WPS did not specifically agree or disagree with our recommendations but described corrective actions that it had taken or planned to take in response to our recommendations. WPS said that it had referred all four of the cost reports identified in our first finding to CMS and that one of the cost reports was awaiting final approval from CMS. Of the 19 cost reports identified in our second finding as having unreconciled outlier payments, WPS stated that 12 cost reports had been finalized, 6 were on hold, and 1 had not yet been approved by CMS. WPS added that for the finalized cost reports, the associated reconciled outlier payments had been collected by the Federal Government or paid to providers as appropriate. WPS also described the controls and procedures it had in place for cost report referral and reconciliation of outlier payments and stated that all cost reports submitted since the end of our audit period had been or would be reviewed accordingly.

After reviewing WPS's comments, we note that nothing in those comments indicated either disagreement with or contradiction of our findings. Moreover, the information that WPS provided in its comments—as to corrective actions as well as the status of the remaining cost reports that were either on hold or awaiting CMS approval—should, when the remaining cost reports are finalized and the corrective actions are fully implemented, align closely with all of our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

In a previous Office of Inspector General (OIG) audit, we reported to CMS that 292 cost reports referred by 9 Medicare contractors for reconciliation had not been settled.[2] In that audit we reviewed outlier cost report data submitted to CMS by 9 selected Medicare contractors that served a total of 15 jurisdictions during our audit period (October 1, 2003, through December 31, 2008). To follow up on that audit, we performed a series of reviews to determine whether the Medicare contractors had (1) referred the cost reports that qualified for reconciliation (a responsibility that already rested with the contractors) and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. One such contractor, Wisconsin Physicians Service Insurance Corporation (WPS), has been since 2007 the Medicare contractor for some legacy providers[3] and for Jurisdiction 5, which comprises Iowa, Kansas, Missouri, and Nebraska.

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

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

[3] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MACs) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable. Moreover, the term "legacy providers" refers to health care providers who were working with other fiscal intermediaries and carriers before the initiation of Medicare contracting reform. More specifically, WPS's legacy providers are those providers that WPS was servicing before the initiation of Medicare contracting reform. Because of these prior relationships, WPS continued to service those providers after the implementation of Medicare contracting reform, even though those providers operate outside of Jurisdiction 5.

OBJECTIVES

Our objectives were to determine whether WPS (1) referred cost reports to CMS for reconciliation in accordance with Federal guidelines and (2) reconciled the outlier payments associated with the referred cost reports by December 31, 2011.[4]

BACKGROUND

Medicare and Outlier Payments

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

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

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

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

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

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

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

whichever is from the latest cost reporting period (42 CFR § 412.84(i)(2)). More than one CCR can be used in a cost reporting period.

A hospital must submit its cost reports, which can include outlier payments, to Medicare contractors within 5 months after the hospital's fiscal year ends. CMS instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report (*Provider Reimbursement Manual*, part 2, § 140). After accepting a cost report,[5] the Medicare contractor completes its preliminary review and may issue a tentative settlement to the hospital. In general, Medicare contractors perform tentative settlements to make partial payments to hospitals owed Medicare funds (although in some cases a tentative settlement may result in a payment from a hospital to Medicare). This practice helps ensure that hospitals are not penalized because of possible delays in the final settlement process.

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

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

In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years[7] after the date of the final settlement of that cost report (42 CFR § 405.1885(b)). We refer to this as the 3-year reopening limit.

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

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

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

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

CMS Changes in the Hospital Outlier Payment Reconciliation Methodology

Outlier Payment Reconciliation

CMS developed new outlier regulations[8] and guidance in 2003 after reporting that, from Federal fiscal years 1998 through 2002, it paid approximately $9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.[9, 10] The 2003 regulations intended to ensure that outlier payments were limited to extraordinarily high-cost cases and that final outlier payments reflected an accurate assessment of the actual costs the hospital had incurred. Medicare contractors were to refer hospitals' cost reports to CMS for reconciliation so CMS could correctly re-price submitted claims and allow Medicare contractors to settle cost reports.[11]

Reconciliation Process

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

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

CMS Transmittal 707[12] provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until

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

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

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

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

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

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

To process the backlog of cost reports requiring reconciliation, CMS instructed Medicare contractors to submit to CMS, between April 1 and April 25, 2011, a list of hospitals whose cost reports had been flagged for reconciliation[14] before April 1, 2011. Further, CMS was to grant approval for Medicare contractors to perform reconciliations for those hospitals with open cost reports. Contractors were then to reconcile, by October 1, 2011, outlier claims that had been flagged before April 1, 2011.

CMS Lump Sum Utility Used in Outlier Recalculation

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

Cost Reports on Hold

In August 2008, CMS instructed Medicare contractors to hold for settlement, rather than settle, any cost reports affected by revised Supplemental Security Income (SSI) ratios. In addition, CMS instructed Medicare contractors to stop issuing final settlements on cost reports using the fiscal years 2006 and 2007 SSI ratios in the calculation of disproportionate share hospital (DSH) payments. CMS subsequently expanded the "DSH/SSI hold" to include cost reports using the fiscal years 2008 and 2009 SSI ratios. The DSH/SSI hold remained in effect until CMS published the updated SSI ratios in June 2012.

HOW WE CONDUCTED THIS REVIEW

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

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

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

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

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

Appendix A contains details of our audit scope and methodology.

FINDINGS

Of 65 cost reports with outlier payments that qualified for reconciliation, WPS referred 61 cost reports to CMS in accordance with Federal guidelines. However, WPS did not refer four cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with two of these four cost reports and (2) the recalculated outlier payments totaled at least $1,819,098. We refer to this difference as financial impact.[15] We also calculated that $1,768,149 was due from Medicare to providers for the other two cost reports of the four that should have been referred to CMS for reconciliation. The net financial impact of the outlier payments associated with these four unreferred cost reports was therefore at least $50,949 that was due to Medicare.

Of the 61 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, WPS had reconciled the outlier payments associated with 42 cost reports by December 31, 2011. However, WPS had not reconciled the outlier payments associated with the remaining 19 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 9 of the 19 cost reports that were referred but not reconciled was at least $11,517,478. We also calculated that $5,823,345 was due from Medicare to providers for 10 of the 19 cost reports that were referred but not reconciled. The net financial impact of the outlier payments associated with these 19 cost reports that were referred but not reconciled was therefore at least $5,694,133 that was due to Medicare.

See Appendix B for a summary of the status of the 65 cost reports with respect to referral and reconciliation, as well as the associated dollar amounts due to Medicare or to providers.

FEDERAL REQUIREMENTS

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

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

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

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

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

COST REPORTS NOT REFERRED

Of 65 cost reports with outlier payments that qualified for reconciliation, WPS referred 61 cost reports to CMS in accordance with Federal guidelines. However, WPS did not refer four cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. WPS did not refer the four cost reports to CMS because WPS had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified and referred to CMS. As a result of the inadequacy of these control procedures:

- WPS did not perform the reconciliation test to identify and refer two cost reports that qualified for reconciliation[16] and

- WPS did not correctly perform the reconciliation test for two other cost reports and incorrectly concluded that those cost reports did not meet the criteria for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these four cost reports totaled at least $1,819,098 that was due to Medicare (two cost reports) and $1,768,149 that was due to providers (two cost reports).[17]

[16] These two cost reports were also on hold because of the SSI-related litigation discussed in "Background."

[17] As stated in "Findings," the net financial impact of the outlier payments associated with these four unreferred cost reports was therefore at least $50,949 that was due to Medicare.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 61 referred cost reports whose outlier payments qualified for reconciliation, WPS reconciled the outlier payments associated with 42 cost reports by December 31, 2011. However, WPS did not reconcile the outlier payments associated with 19 cost reports by December 31, 2011. The statuses of the cost reports with unreconciled outlier payments were as follows:

- 9 cost reports were on hold because CMS had not calculated revised SSI ratios and

- 10 cost reports had been correctly referred but were still being processed before final settlement (that is, the 10 cost reports were awaiting CMS approval to reconcile the outlier payments).

For the 19 cost reports that were referred but whose outlier payments had not been reconciled, CMS bore principal responsibility for the delays that we have described above.[18]

For the 19 referred cost reports whose outlier payments WPS did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least $11,517,478 that was due to Medicare (9 cost reports) and $5,823,345 that was due to providers (10 cost reports).[19]

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with the four unreferred cost reports that were within the 3-year reopening limit was at least $1,819,098 that was due to Medicare (two cost reports) and $1,768,149 that was due to providers (two cost reports). These cost reports should have been referred to CMS for reconciliation but were not and were also not reconciled even though their outlier payments qualified for reconciliation.

Finally, for the 19 referred cost reports whose outlier payments WPS did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least $11,517,478 that was due to Medicare (9 cost reports) and $5,823,345 that was due to providers (10 cost reports). Therefore, the net financial impact to Medicare of the 19 cost reports with unreconciled outlier payments was at least $5,694,133.

[18] We will report separately to CMS on issues related to cost report referral and outlier payment reconciliation in a future review.

[19] As stated in "Findings," the net financial impact of the outlier payments associated with these 19 cost reports that were referred but not reconciled was therefore at least $5,694,133 that was due to Medicare.

RECOMMENDATIONS

We recommend that WPS:

- review the 4 cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation but were not; take appropriate actions to refer these cost reports; and request CMS approval to:

    - recoup $1,819,098 in funds and associated interest from health care providers (2 cost reports) and refund that amount to the Federal Government and

    - return $1,768,149 in funds and associated interest from Medicare to providers (2 cost reports);

- review the 19 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:

    - reconcile the $11,517,478 in associated outlier payments due to the Federal Government (9 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and

    - reconcile the $5,823,345 in associated outlier payments due from Medicare to providers (10 cost reports), finalize these cost reports, and return the funds to the providers;

- strengthen control procedures to ensure that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;

- strengthen policies and procedures to ensure that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and

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

AUDITEE COMMENTS

In written comments to our draft report, WPS did not specifically agree or disagree with our recommendations but described corrective actions that it had taken or planned to take in response to our recommendations. Specifically, WPS said that it had either referred or finalized most of the cost reports identified in our findings. WPS added that for the finalized cost reports, the associated reconciled outlier payments had been collected by the Federal Government or paid to providers as appropriate. WPS provided the following information on the current status of the cost reports identified in our findings and associated recommendations.

For the four cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation but were not, WPS said that it had referred all four cost reports to CMS. WPS stated that of these, one cost report had been finalized, with $1,902,207 paid to the provider, and added that two others had been finalized, with $1,584,418 in associated outlier payments having been collected by the Federal Government. WPS described the fourth cost report as being on hold because it was awaiting final approval from CMS.

For the nine cost reports that were referred to CMS, had outlier payments that qualified for reconciliation, and had amounts due to the Federal Government, WPS stated that two cost reports had been finalized and that $3,132,564 in associated outlier payments had been collected. WPS added that six cost reports were still on hold awaiting revised SSI ratios and that the remaining cost report was on hold because it was awaiting final approval from CMS.

For the 10 cost reports that were referred to CMS, had outlier payments that qualified for reconciliation, and had amounts due to providers, WPS stated that all 10 cost reports had been finalized and that $5,781,870 had been paid to providers.

With respect to our last three recommendations, WPS described the controls and procedures it had in place to ensure that all outlier payments that qualify for reconciliation are reconciled before final settlement. WPS also stated that all cost reports submitted since the end of our audit period had been or would be reviewed as part of the final settlement process in accordance with its controls and procedures.

WPS's comments appear in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing WPS's comments, we note that nothing in those comments indicated either disagreement with or contradiction of our findings. Moreover, the information that WPS provided in its comments—as to corrective actions as well as the status of the remaining cost reports that were either on hold or awaiting CMS approval—should, when the remaining cost reports are finalized and the corrective actions are fully implemented, align closely with all of our recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether WPS had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.[20] If the cost reports had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and calculated the amounts due to Medicare or to providers.

We performed fieldwork at WPS's office in Omaha, Nebraska, and followup audit work in our Denver, Colorado, field office, from November 2010 to October 2013.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to WPS and other Medicare contractors concerning the reconciliation process and responsibilities;
- obtained from CMS a list of cost reports that Medicare contractors had referred for reconciliation;
- held discussions with WPS officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed WPS's policies and procedures regarding referral to CMS and reconciliation of cost reports;
- reviewed provider lists from all Medicare contractors to determine which providers were under WPS's jurisdiction as of November 22, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that WPS had referred to CMS for reconciliation during our audit period;
- obtained the cost report data from CMS's database for cost reports with fiscal-year ends during our audit period;

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

- obtained the Inpatient Acute Care and LTCH provider specific files (PSFs) from the CMS Web site;

- determined which cost reports qualified for reconciliation by:

    - using the information in a CMS database to identify acute-care and long-term-care cost reports that had greater than $500,000 in outlier payments[21] and

    - using the information in CMS's database and PSF data to calculate and compare the actual and weighted average CCRs to determine whether the resulting variance was greater than 10 percentage points;

- verified that WPS used the three different types of outlier payments specified by Federal regulations[22] (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;

- requested that WPS provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;[23]

- reviewed WPS's response and categorized the cost reports according to their respective statuses;

- verified whether WPS had referred the cost reports before the date of the audit notification letter;

- verified that all of the cost reports we reviewed met the criteria for reconciliation;

- performed the following actions for cost reports that qualified for outlier reconciliation but for which WPS did not recalculate the outlier payments:

    - obtained the detailed Provider Statistical & Reimbursement reports from WPS or obtained the National Claims History data from CMS;

    - verified the original outlier payments using the CCR that was used to pay the claim;

    - recalculated the outlier payment amounts for those cost reports that WPS did not recalculate using the actual CCRs; and

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

[22] Claims Processing Manual, chapter 3, § 20.1.2.5.

[23] Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by WPS.

- calculated accrued interest[24] as of the date that the cost report was referred to CMS (for unreferred cost reports or those that were referred after December 31, 2011, we calculated the amount of accrued interest as of December 31, 2011);

- summarized the results of our analysis including the total amount due to or from Medicare; and

- provided the results of our review to WPS officials on October 16, 2013.

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.

[24] We calculated interest by referring to the Claims Processing Manual, § 20.1.2.6.

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

Table 1: Total Cost Reports and Amounts Due

Grand Total	Due to Medicare	Due to Providers
65 Cost Reports	$72,351,954	$13,994,753

Table 2: Cost Reports Not Referred (OIG Identified)

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years				
		In Process	On Hold	Past 3 Years	Not Reconciled Subtotal	
Number of Cost Reports	0	2	2	0	4	4
Balance Due to Medicare	$0	$0	$1,456,128	$0	$1,456,128	$1,456,128
Interest Due to Medicare	0	0	362,970	0	362,970	362,970
Balance Due to Provider	0	1,482,795	0	0	1,482,795	1,482,795
Interest Due to Provider	0	285,354	0	0	285,354	285,354
Total Due to Medicare	**0**	**0**	**$1,819,098**	**$0**	**$1,819,098**	**$1,819,098**
Total Due to Provider	**$0**	**$1,768,149**	**$0**	**$0**	**$1,768,149**	**$1,768,149**

Table 3: Cost Reports Referred (Medicare Contractor Identified)

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		Past 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
Number of Cost Reports	42	10	9	0	19	61
Balance Due to Medicare	$53,871,583	$863,737	$9,644,050	$0	$10,507,787	$64,379,370
Interest Due to Medicare	5,143,795	113,516	896,175	0	1,009,691	6,153,486
Balance Due to Provider	5,956,548	4,461,835	859,333	0	5,321,168	11,277,716
Interest Due to Provider	446,711	430,927	71,250	0	502,177	948,888
Total Due to Medicare	**$59,015,378**	**$977,253**	**$10,540,225**	**$0**	**$11,517,478**	**$70,532,856**
Total Due to Provider	**$6,403,259**	**$4,892,762**	**$930,583**	**$0**	**$5,823,345**	**$12,226,604**

APPENDIX C: AUDITEE COMMENTS

Medicare

August 15, 2014

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: Office of Inspector General (OIG) Draft Report – A-07-10-02777

Dear Mr. Cogley,

This letter is in response to the OIG draft report titled *Wisconsin Physicians Service Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required.*

OIG *compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether WPS had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.*

Of 65 cost reports with outlier payments that qualified for reconciliation, WPS referred 61 cost reports to CMS in accordance with Federal guidelines. However, WPS did not refer four cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. We calculated that, as of December 31, 2011, the difference between (1) the outlier payments associated with two of these four cost reports and (2) the recalculated outlier payments totaled at least $1,819,098. We refer to this difference as financial impact. We also calculated that $1,768,149 was due from Medicare to providers for the other two cost reports of the four that should have been referred to CMS for reconciliation.

Of the 61 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, WPS had reconciled the outlier payments associated with 42 cost reports by December 31, 2011. However, WPS had not reconciled the outlier payments associated with the remaining 19 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 9 of the 19 cost reports that were referred but not reconciled was at least $11,517,478. We also calculated that $5,823,345 was due from Medicare to providers for 10 of the 19 cost reports that were referred but not reconciled.

OIG Recommendations to WPS and WPS' response to Recommendations:

- *review the 4 cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation but were not; take appropriate actions to refer these cost reports; and request CMS approval to:*
  - *recoup $1,819,098 in funds and associated interest from health care providers (2 cost reports) and refund that amount to the Federal Government and*
  - *return $1,768,149 in funds and associated interest from Medicare to providers (2 cost reports);*

Wisconsin Physicians Service Insurance Corporation serving as a CMS Medicare Contractor
P.O. Box 1787 • Madison, WI 53701 • Phone 608-221-4711

- *review the 19 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:*

    - *reconcile the $11,517,478 in associated outlier payments due to the Federal Government (9 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and*

    - *reconcile the $5,823,345 in associated outlier payments due from Medicare to providers (10 cost reports), finalize these cost reports, and return the funds to the providers;*

- *strengthen control procedures to ensure that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;*

- *strengthen policies and procedures to ensure that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and*

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

WPS Response to the OIG Recommendations:

- *review the 4 cost reports that had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation but were not; take appropriate actions to refer these cost reports; and request CMS approval to:*

    - *recoup $1,819,098 in funds and associated interest from health care providers (2 cost reports) and refund that amount to the Federal Government and*

    - *return $1,768,149 in funds and associated interest from Medicare to providers (2 cost reports);*

WPS' Response:

The four cost reports referenced in this recommendation were identified by WPS as requiring an outlier reconciliation, prompted by either additional instructions or clarifications issued by CMS or by a provider request. These cost reports have all been referred to CMS for approval. Of these four cost reports, one was finalized during September, 2012 and $1,902,207 was paid to the provider. Two were finalized during November 2012 and $1,584,418 was collected. The remaining provider is still on hold as we are awaiting final approval from CMS.

- *review the 19 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:*

    - *reconcile the $11,517,478 in associated outlier payments due to the Federal Government (9 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and*

    - *reconcile the $5,823,345 in associated outlier payments due from Medicare to providers (10 cost reports), finalize these cost reports, and return the funds to the providers;*

WPS' Response:

Of the nine cost reports with payments due the Federal Government, two were finalized during June and August, 2012 and $3,132,564 was collected. Six are still on hold awaiting revised SSI ratios. One has not been approved by CMS.

The ten cost reports with amounts due the provider were finalized between May and August 2012 with $5,781,870 paid to the providers.

- *strengthen control procedures to ensure that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;*

WPS' Response:

Currently WPS has in place specific work instructions, forms and checklists designed to ensure that all cost reports are reviewed prior to final settlement to identify those that qualify for an outlier reconciliation and properly referred to CMS for their approval prior to processing the final settlement. These procedures have been reviewed periodically and in response to clarifications and are currently up to date.

- *strengthen policies and procedures to ensure that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and*

WPS' Response:

Currently WPS has in place specific work instructions, forms and checklists designed to ensure that all outlier payments associated with cost reports that qualify for a reconciliation are reconciled prior to final settlement. These procedures have been reviewed periodically and in response to clarifications and are currently up to date. WPS has been actively involved with the system maintainer to identify issues with the FISS Lump Sum Utility and to assist with resolving those issues to ensure that reconciliations are performed timely and accurately.

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

WPS' Response:

All cost reports submitted since the end of the audit period have been or will be reviewed as part of our final settlement process in accordance with our control procedures.

If you have any questions or need additional information, please contact me at 402-995-0443.

Sincerely,

Mark DeFoil
Director, Contract Coordination

cc: John Michelson, CMS
Marsha Mills, CMS
James Massa, CMS
Debra Keasling, OIG