Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CGS ADMINISTRATORS, LLC, DID NOT ALWAYS REFER MEDICARE COST REPORTS AND RECONCILE OUTLIER PAYMENTS

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EXECUTIVE SUMMARY

CGS Administrators, LLC, did not always* refer *cost reports whose outlier payments qualified for reconciliation to the Centers for Medicare & Medicaid Services. The financial impact of the unreferred cost report was at least $279,000 that should be recouped from health care providers and returned to Medicare. In addition, CGS did not always* reconcile *the outlier payments associated with cost reports whose outlier payments qualified for reconciliation.

WHY WE DID THIS REVIEW

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

This review is one of a series of reviews to determine whether Medicare contractors had (1) referred the cost reports that qualified for reconciliation and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. One such contractor, CGS Administrators, LLC (CGS), had been since 2011 the Medicare contractor for Jurisdiction 15, which comprises Kentucky and Ohio.

The objectives of this review were to determine whether CGS (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 CGS 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 18 cost reports with outlier payments that qualified for reconciliation, CGS referred 15 cost reports to CMS in accordance with Federal guidelines. However, CGS did not refer three cost reports that should have been referred to CMS for reconciliation. Of these, one cost report had not been settled 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 this cost report and (2) the recalculated outlier payments totaled at least $279,156. We refer to this difference as financial impact. The two remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation; the financial impact of the outlier payments associated with those two cost reports totaled $1,831,479.

Of the 15 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, CGS had reconciled the outlier payments associated with 1 cost report by December 31, 2011. However, CGS had not reconciled the outlier payments associated with the remaining 14 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 11 of the 14 cost reports that were referred but not reconciled was at least $18,260,020. We also calculated that $2,054,252 was due from Medicare to providers for 2 of the 14 cost reports that were referred but not reconciled. The net financial impact of the outlier payments associated with these 13 cost reports that were referred but not reconciled was therefore at least $16,205,768 that was due to Medicare. For the remaining cost report that exceeded the 3-year reopening limit and should have been reconciled, the financial impact of the outlier payments totaled $451,025 that may be due to Medicare.

WHAT WE RECOMMEND

We recommend that CGS:

- review the 1 cost report that had not been settled and should have been referred to CMS for reconciliation but was not, take appropriate actions to refer the cost report, request CMS approval to recoup $279,156 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

- review the 2 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not; determine whether these cost reports may be reopened; and work with CMS to resolve $1,831,479 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the 13 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:

    - reconcile the $18,260,020 in associated outlier payments due to the Federal Government (11 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and

    - reconcile the $2,054,252 in associated outlier payments due from Medicare to providers (2 cost reports), finalize these cost reports, and return the funds to the providers;

- review the 1 cost report that had exceeded the 3-year reopening limit, was referred to CMS, and should have been reopened but was not; determine whether the cost report may be reopened; and work with CMS to resolve the $451,025 in funds and associated interest that may be due from a health care provider to the Federal Government;

- continue to 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;

- continue to 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 on our draft report, CGS concurred with our first recommendation, did not concur with our second and fourth recommendations, and described corrective actions that it had taken in response to our other recommendations. CGS did not concur with our findings because it said that those findings conflicted with established guidance. CGS also said it was not responsible for the cost reports reviewed and cited in the report until October 17, 2011.

After reviewing CGS's comments, we maintain that all of our findings and recommendations remain valid. We disagree with CGS's statement that the cost reports and providers discussed in this audit report were not CGS's responsibility. CGS was not originally responsible for all of the cost reports discussed in this audit report, but as a Medicare contractor since 2011 for Jurisdiction 15, CGS now services these cost reports and is therefore responsible for resolving our recommendations associated with them.

Cost Reports Not Referred

Auditee Comments

CGS concurred with our first recommendation but did not concur with the associated finding that CGS did not refer one cost report that had not been settled, was within the 3-year reopening limit, and should have been referred to CMS for reconciliation. CGS cited CGS guidance stating that the outlier reconciliation process should be completed at the time of final settlement of a cost report. CGS added that CMS instructions regarding final settlement of cost reports placed on hold had caused the previous Medicare contractor to delay the settlement of this cost report. CGS stated that it referred this cost report to CMS after the hold was lifted.

CGS did not concur with our second recommendation or with the associated finding that it did not refer two cost reports that had exceeded the 3-year reopening limit. CGS said that it was unable to take further action on these two cost reports because the 3-year reopening limit had passed before responsibility for them had transferred to CGS.

Our Response

For the one unreferred cost report that was within the 3-year reopening limit and that qualified for reconciliation, CGS's comments confirmed our finding that this cost report had not been referred to CMS as of the start of our audit. CGS's comments about the delays in settlement of this cost report that had been placed on hold also agreed with our discussion.

Although the CMS guidance cited by CGS states that the outlier reconciliation process should be completed at the time of final settlement of a Medicare cost report, 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 before April 1, 2011. CGS confirmed in its comments that this cost report had not been flagged for reconciliation by the previous contractor before it was transferred to CGS as part of the transition in Medicare contractor responsibilities. CGS did not refer this cost report to CMS for outlier reconciliation until October 2, 2012. Moreover, CMS has established timeframes within which Medicare contractors bring cost reports to final settlement. Additionally, CMS instructions regarding cost reports placed on hold do not state that Medicare contractors are to forego performing the reconciliation tests before the hold is lifted. Finally, Medicare contractors should identify cost reports that qualify for outlier reconciliation and refer them to CMS as soon as possible to avoid the unnecessary accrual of additional costs (i.e., interest) due to Medicare or to providers.

With respect to the two unreferred cost reports that had exceeded the 3-year reopening limit, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "fraud or similar fault."

Cost Reports Referred but Outlier Payments Not Reconciled

Auditee Comments

For the 13 cost reports that were referred to CMS, were within the 3-year reopening limit, and had outlier payments that qualified for reconciliation, CGS did not directly agree or disagree with our third recommendation but said that all of these cost reports had now been finalized. For five of these cost reports, CGS attributed the delays in reconciling the outlier payments to CMS instructions regarding cost reports placed on hold and to problems with specialized software. CGS said that the eight remaining cost reports were reconciled timely by the previous Medicare contractor.

CGS did not concur with our fourth recommendation or with the associated finding that it did not reconcile the outlier payments for one cost report that had exceeded the 3-year reopening limit. CGS said that it was unable to take further action on this cost report because the 3-year reopening limit had passed before responsibility for it had transferred from the previous Medicare contractor to CGS.

Our Response

Our report gives a status update and does not opine as to whether the cost reports were reconciled in accordance with any CMS-established deadlines. Furthermore, our report notes that CMS bore principal responsibility for the delays associated with the cost reports placed on hold and/or pending updates to the specialized software. For the other cost reports that were within the 3-year reopening limit and that CGS said were reconciled timely by the previous Medicare contractor, CGS confirmed in its comments and in documentation obtained during our fieldwork that these cost reports had not been brought to final settlement before our December 31, 2011, cutoff date.

With respect to the cost report that had exceeded the 3-year reopening limit and whose associated outlier payments had not been reconciled, we disagree with CGS's statement that further action cannot be taken beyond 3 years after the date of the cost reports' final settlement; see our response to CGS's comments in "Cost Reports Not Referred" above.

Procedural Recommendations

Auditee Comments

CGS did not directly agree or disagree with our last three recommendations and said that it had standardized work instructions and control procedures and that it had properly completed the reconciliation process on all cost report final settlements and submitted them timely.

Our Response

Our findings and our responses to CGS's comments provide the evidence for our conclusion that CGS's control procedures regarding cost report referral and its policies and procedures for reconciliation of outlier payments were not always adequate.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

In a previous Office of Inspector General (OIG) audit, we reported to CMS that 292 cost reports referred by 9 Medicare contractors for reconciliation had not been settled.[2] In that audit we reviewed outlier cost report data submitted to CMS by 9 selected Medicare contractors that served a total of 15 jurisdictions during our audit period (October 1, 2003, through December 31, 2008). To follow up on that audit, we performed a series of reviews (Appendix A) 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, CGS Administrators, LLC (CGS), had been since 2011 the Medicare contractor for Jurisdiction 15, which comprises Kentucky and Ohio.

OBJECTIVES

Our objectives were to determine whether CGS (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.[3]

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.

[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] 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.

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 accurately reflect 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 when a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost-reporting period (42 CFR § 412.84(i)(2)). More than one CCR can be used in a cost-reporting period.

A hospital must submit its cost reports, which can include outlier payments, to Medicare contractors within 5 months after the hospital's fiscal year ends. CMS instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report (*Provider Reimbursement Manual*, part 2 (PRM-2), § 140). After accepting a cost report,[4] 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

[4] 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.

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.[5] 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[6] 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.

CMS Changes in the Hospital Outlier Payment Reconciliation Methodology

Outlier Payment Reconciliation

CMS developed new outlier regulations[7] 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.[8, 9] The 2003 regulations intended to ensure that

[5] 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.

[6] 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 (PRM-1), § 2931.1 (F)).

[7] 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).

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

[9] 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.

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 enable Medicare contractors to settle cost reports.[10]

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[11] 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,[12] 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[13] before April 1, 2011. Further, CMS was to grant approval for Medicare contractors to perform reconciliations for those hospitals with open cost

[10] 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.

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

[12] 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).

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

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

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

Appendix B contains details of our audit scope and methodology.

FINDINGS

Of 18 cost reports with outlier payments that qualified for reconciliation, CGS referred 15 cost reports to CMS in accordance with Federal guidelines. However, CGS did not refer three cost reports that should have been referred to CMS for reconciliation. Of these, one cost report had

not been settled 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 this cost report and (2) the recalculated outlier payments totaled at least $279,156. We refer to this difference as financial impact.[14] The two remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation; the financial impact of the outlier payments associated with those two cost reports totaled $1,831,479.

Of the 15 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, CGS had reconciled the outlier payments associated with 1 cost report by December 31, 2011. However, CGS had not reconciled the outlier payments associated with the remaining 14 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 11 of the 14 cost reports that were referred but not reconciled was at least $18,260,020. We also calculated that $2,054,252 was due from Medicare to a provider for 2 of the 14 cost reports that were referred but not reconciled. The net financial impact of the outlier payments associated with these 13 cost reports that were referred but not reconciled was therefore at least $16,205,768 that was due to Medicare. For the remaining cost report that exceeded the 3-year reopening limit and should have been reconciled, the financial impact of the outlier payments totaled $451,025 that may be due to Medicare.

See Appendix C for a summary of the status of the 18 cost reports with respect to referral and reconciliation, as well as the associated dollar amounts due to Medicare or to the provider.

FEDERAL REQUIREMENTS

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

If a hospital's total outlier payments during the cost-reporting period exceed $500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during that period to 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.

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

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 18 cost reports with outlier payments that qualified for reconciliation, CGS referred 15 cost reports to CMS in accordance with Federal guidelines. However, CGS did not refer three cost reports that should have been referred to CMS for reconciliation.

Cost Report Within the 3-Year Reopening Limit

Of the three cost reports that CGS did not refer to CMS for reconciliation, one had not been settled and should have been referred to CMS for reconciliation. Because CGS had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified and referred to CMS, it did not perform the reconciliation test to identify and refer this cost report.[15] We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with this unreferred cost report totaled at least $279,156 that was due to Medicare.

Cost Reports Outside the 3-Year Reopening Limit

Of the three cost reports that CGS did not refer to CMS for reconciliation, the remaining two cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. CGS did not refer the two cost reports to CMS because they had exceeded the 3-year reopening limit by the time CGS became the Medicare contractor responsible for those cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these two cost reports totaled at least $1,831,479 that may be due to Medicare.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 15 referred cost reports whose outlier payments qualified for reconciliation, CGS reconciled the outlier payments associated with 1 cost report by December 31, 2011. However, CGS did not reconcile the outlier payments associated with 14 cost reports by December 31, 2011.

[15] This cost report was also on hold because of the SSI-related litigation discussed in "Background."

Cost Reports Within the 3-Year Reopening Limit

Of the 14 referred cost reports whose outlier payments qualified for reconciliation, 13 cost reports were not settled; the outlier payments associated with these 13 cost reports should have been reconciled. The statuses of these cost reports with unreconciled outlier payments were as follows:

- three cost reports were on hold because CMS had not calculated revised SSI ratios,
- two cost reports were on hold because CMS had not calculated revised SSI ratios and because of pending updates to the FISS Lump Sum Utility software that prevented the recalculation of outlier payments, and
- eight cost reports had been correctly referred but were still being processed before final settlement (six cost reports had received CMS approval and were undergoing the reconciliation process and two were pending updates to the FISS Lump Sum Utility software).

For the six cost reports that had received CMS approval and were undergoing the reconciliation process, CGS's policies and procedures did not ensure that it reconciled all outlier payments associated with all referred cost reports that qualified for reconciliation in accordance with Federal guidelines. For the other seven 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.[16]

For the 13 referred cost reports that were not settled and whose outlier payments CGS did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least $18,260,020 that was due to Medicare (11 cost reports) and $2,054,252 that was due to providers (2 cost reports).[17]

Cost Report Outside the 3-Year Reopening Limit

Of the 14 referred cost reports whose outlier payments qualified for reconciliation, the remaining 1 cost report was brought to final settlement without its outlier payments being reconciled. This cost report went beyond the 3-year reopening limit without being reopened. CGS did not reconcile this cost report because it had exceeded the 3-year reopening limit by the time CGS became the Medicare contractor responsible for it. For the one cost report that exceeded the 3-year reopening limit and whose outlier payments CGS did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least $451,025 that may be due to Medicare.

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

[17] As stated in "Findings," the net financial impact of the outlier payments associated with these 13 cost reports that were referred but not reconciled was at least $16,205,768 that was due to Medicare.

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with the one unreferred cost report that was within the 3-year reopening limit was at least $279,156 that was due to Medicare. This cost report should have been referred to CMS for reconciliation but was not and was also not reconciled even though its outlier payments qualified for reconciliation.

Also as of December 31, 2011, the financial impact of the outlier payments associated with the two cost reports that exceeded the 3-year reopening limit and that should have been referred to CMS for reconciliation but were not was at least $1,831,479 that may be due to Medicare.

In addition, for the 13 referred cost reports that were within the 3-year reopening limit and whose outlier payments CGS did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least $18,260,020 that was due to Medicare (11 cost reports) and $2,054,252 that was due to providers (2 cost reports). Therefore, the net financial impact to Medicare of the 13 cost reports that were within the 3-year reopening limit with unreconciled outlier payments was at least $16,205,768.

Finally, for the one referred cost report that exceeded the 3-year reopening limit and whose outlier payments CGS did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least $451,025 that may be due to Medicare.

RECOMMENDATIONS

We recommend that CGS:

- review the 1 cost report that had not been settled and should have been referred to CMS for reconciliation but was not, take appropriate actions to refer the cost report, request CMS approval to recoup $279,156 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

- review the 2 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not; determine whether these cost reports may be reopened; and work with CMS to resolve $1,831,479 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the 13 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:

    - reconcile the $18,260,020 in associated outlier payments due to the Federal Government (11 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and

- reconcile the $2,054,252 in associated outlier payments due from Medicare to providers (2 cost reports), finalize these cost reports, and return the funds to the providers;

- review the 1 cost report that had exceeded the 3-year reopening limit, was referred to CMS, and should have been reopened but was not; determine whether the cost report may be reopened; and work with CMS to resolve the $451,025 in funds and associated interest that may be due from a health care provider to the Federal Government;

- continue to 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;

- continue to 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 OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CGS concurred with our first recommendation, did not concur with our second and fourth recommendations, and described corrective actions that it had taken in response to our other recommendations. CGS did not concur with our findings because it said that those findings conflicted with established guidance. A summary of CGS's comments and our response follows.

CGS's comments, within which we have redacted proprietary information, appear as Appendix D. We are separately providing CGS's comments in their entirety to CMS.

After reviewing CGS's comments, we maintain that all of our findings and recommendations remain valid.

MEDICARE CONTRACTOR RESPONSIBILITIES

Auditee Comments

In its comments on our draft report, CGS asked that its name be removed from the title of this report because it said it was not responsible for the cost reports reviewed and cited in the report until October 17, 2011. CGS added that it "… had no opportunity to influence actions taken on 13" of the cost reports cited in our findings.

Office of Inspector General Response

We disagree with CGS's statement that the cost reports and providers discussed in this audit report were never CGS's responsibility. 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 contractors, a process known as Medicare contracting reform. Pursuant to this legislation, CMS contracted with Medicare contractors (such as CGS), who had either won new Medicare contracts, retained the contracts that they had before implementation of this legislation, or gained new jurisdictions, providers, or both. Under these contracts, the Medicare contractor assumed responsibility to administer functions previously carried out by fiscal intermediaries, carriers, and Medicare contractors with regard to providers and cost reports.[18] CGS was not originally responsible for all of the cost reports discussed in this audit report. However, as of October 17, 2011, when CGS became the Medicare contractor for Jurisdiction 15, CGS was responsible for the providers and cost reports that were under the jurisdiction of the previous fiscal intermediary and is now responsible for resolving our recommendations associated with them.[19]

COST REPORTS NOT REFERRED

Cost Report Within the 3-Year Reopening Limit

Auditee Comments

CGS concurred with our first recommendation but did not concur with the associated finding that CGS did not refer one cost report that had not been settled and should have been referred to CMS for reconciliation. CGS said that the Claims Processing Manual, chapter 3, section 20.1.2.5, states that the outlier reconciliation process should be completed at the time of final settlement of a cost report. CGS added that CMS instructions regarding final settlement of cost reports because of the DSH/SSI hold had caused the previous Medicare contractor to delay the settlement of this cost report. After the DSH/SSI hold was lifted on June 8, 2012, CGS referred the cost report (on October 2, 2012) to CMS.

Office of Inspector General Response

CGS's comments confirmed that the one unreferred cost report that was within the 3-year reopening limit and that qualified for reconciliation had not been referred to CMS as of December 28, 2010 (the start of our audit). CGS's comments about the delays in settlement of this cost report also agreed with our own discussion of the DSH/SSI hold ("Cost Reports on Hold" and footnote 15).

[18] *Part A and Part B Medicare Administrative Contractor Statement of Work*, sections C.1 and C.5.

[19] CMS, *J15 Part A and Part B Medicare Administrative Contractor (A/B MAC) New Workload Numbers for States of Kentucky, Ohio and the Regional Home Health intermediary (RHHI) Region B Workloads, as well as the Split of the Customer Information Controls System (CICS) Production and UAT* [User Acceptance Testing] *Regions for the Part B Ohio/West Virginia Workloads and the Part B Kentucky/Indiana Workloads*, Transmittal 830 (Change Request 6999; January 7, 2011).

We agree with CGS that chapter 3, section 20.1.2.5, of the Claims Processing Manual states that the outlier reconciliation process should be completed at the time of final settlement of a Medicare cost report. CGS confirmed in its comments that this cost report had not been flagged for reconciliation by the previous contractor before it was transferred to CGS on October 17, 2011, as part of the transition in Medicare contractor responsibilities. CGS did not refer this cost report to CMS for outlier reconciliation until October 2, 2012.

Although chapter 3, section 20.1.2.5, of the Claims Processing Manual does not specify a timeframe within which a cost report that requires reconciliation has to be referred to CMS, CMS has established timeframes within which Medicare contractors must settle cost reports and issue NPRs:

- The PRM-1, chapter 29, section 2905, states that Medicare contractors must issue NPRs "within a reasonable period of time."

- The PRM-1, chapter 29, section 2905.1, states that Medicare contractors are to "make every attempt to issue a NPR within 12 months of receipt of a cost report."

- Chapter 8, section 90, of the *Medicare Financial Management Manual* states that CMS expects Medicare contractors to settle all cost reports that are not scheduled for audit within 12 months of acceptance of the cost report unless there is a documented reason why the cost report cannot be settled.

To meet the 12-month deadline, tentative adjustments are made "as soon as [a] cost report is received" by a Medicare contractor (PRM-1, chapter 24, § 2408.2), and the Medicare contractor has 30 days from the date of receipt of a provider's cost report to make a determination of acceptability (PRM-2, chapter 1, § 140).

In addition, we recognize that CGS could not issue a final NPR until the DSH/SSI hold had been lifted.[20] Nevertheless, CMS instructions regarding cost reports subject to the DSH/SSI hold do not state that Medicare contractors are to forego performing reconciliation tests before the DSH/SSI hold is lifted.

Finally, our calculations of the financial impact of our findings took into account the time value of money (i.e., interest). Because these calculations are based on the cost report referral dates, delays in referring a cost report that qualifies for reconciliation increase the amounts due from providers to Medicare or due from Medicare to providers. Therefore, Medicare contractors should identify cost reports that qualify for reconciliation and refer them to CMS as soon as possible to avoid the unnecessary accrual of additional costs due to Medicare or to providers.

[20] See "Cost Reports on Hold" earlier in this report.

Cost Reports Outside the 3-Year Reopening Limit

Auditee Comments

Our report identifies two unreferred cost reports that had exceeded the 3-year reopening limit. CGS did not concur with either this finding or the associated recommendation (our second recommendation). CGS stated that the previous Medicare contractor had settled both of these cost reports and that the 3-year reopening limit had passed before responsibility for them had transferred (on October 17, 2011) to CGS. CGS added that it was therefore unable to take further action.

Office of Inspector General Response

CGS's comments confirmed that the two unreferred cost reports that had exceeded the 3-year reopening limit and that qualified for reconciliation had not been referred to CMS as of December 28, 2010 (the start of our audit).

CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "fraud or similar fault." Specifically, a Medicare payment contractor (e.g., CGS) may reopen an initial determination *at any time* if the determination was procured by fraud or similar fault (42 CFR § 405.1885(b)(3)). For example, a Medicare payment contractor may reopen a cost report after determining that a provider received money that it knew or reasonably should have known it was not entitled to retain (73 Fed. Reg. 30190, 30233 (May 23, 2008)). Because the outlier reconciliation rules are promulgated in Federal regulations, providers knew or should have known the rules when their cost reports were settled. We believe that these regulations constitute a sufficient basis for our second recommendation and recognize that ultimately, CMS, as the cognizant Federal agency, has the authority to decide how to resolve these and the other recommendations in this audit report. Accordingly, we continue to recommend that CGS determine whether these two providers procured Medicare funds by "similar fault" and work with CMS to resolve their $1,831,479 in outlier payments.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED[21]

Cost Reports Within the 3-Year Reopening Limit

Auditee Comments

For the 13 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation, CGS did not directly agree or disagree with our third recommendation but said

[21] At several points in CGS's comments, CGS speaks in terms of 15 referred cost reports whose outlier payments qualified for reconciliation but had not been reconciled (by December 31, 2011). However, we state (in "Cost Reports Referred But Outlier Payments Not Reconciled") that CGS reconciled the outlier payments associated with 1 of these cost reports by December 31, 2011, and that 14 (not 15) cost reports had not been reconciled by that date.

that all of these cost reports had now been finalized.[22] With respect to the associated findings, CGS stated that it did not complete the reconciliations for three cost reports in response to CMS instructions for cost reports subject to the DSH/SSI hold. CGS added that it reconciled the outlier payments for these three cost reports after CMS published the updated SSI percentages (referred to as "revised SSI ratios" in our finding). For two other cost reports, CGS stated that the delays in reconciling the outlier payments were due to problems with the FISS Lump Sum Utility software and added that it finalized these cost reports on April 23 and June 18, 2014, respectively. CGS said that the eight remaining cost reports were reconciled timely by the previous Medicare contractor.

Office of Inspector General Response

We determined the status of the reconciliation process for each cost report as of December 31, 2011. While our selection of December 31, 2011, as a cutoff date provided a 3-month grace period beyond the CMS-established deadline of October 1, 2011, our report provides a status update and does not opine as to whether the cost reports were reconciled in accordance with any CMS-established deadlines. Furthermore, our report notes that CMS bore principal responsibility for the delays associated with the cost reports that were on hold for SSI-related litigation and/or were pending updates to the FISS Lump Sum Utility software. For the other cost reports that CGS stated were reconciled timely by the previous Medicare contractor, CGS confirmed in its comments and in documentation obtained during our fieldwork that these cost reports had not been brought to final settlement before the December 31, 2011, cutoff date that we used.

Cost Reports Outside the 3-Year Reopening Limit

Auditee Comments

For the one cost report that had been settled, had exceeded the 3-year reopening limit, and whose outlier payments had not been reconciled, CGS did not concur with either this finding or the associated recommendation (our fourth recommendation). CGS stated that the previous Medicare contractor had settled the cost report and that the 3-year reopening limit had passed before responsibility for this cost report had transferred (on October 17, 2011) to CGS. CGS added that it was therefore unable to take further action.

Office of Inspector General Response

CGS's comments confirmed that this cost report had been settled by the previous contractor and had exceeded the 3-year reopening limit by the time responsibility for it had transferred to CGS. Our finding acknowledges that this cost report had exceeded the 3-year reopening limit by the

[22] This portion of CGS's discussion (the third page of Appendix D) refers to an "attached document" that depicted the submission dates of these cost reports to CMS. CGS did not include that attachment. When we inquired about the attachment, CGS said that it had overlooked the need to remove the reference to the attached document and advised us to disregard it.

time CGS became the Medicare contractor responsible for it. However, we disagree with CGS's statement that further action cannot be taken beyond 3 years after the date of the cost report's final settlement for the same reasons that we stated in the "Office of Inspector General" response to CGS's comments regarding the two unreferred cost reports that had exceeded the 3-year reopening limit. Accordingly, we continue to recommend that CGS determine whether the provider procured Medicare funds by "similar fault" and work with CMS to resolve their $451,025 in outlier payments.

PROCEDURAL RECOMMENDATIONS

Our first four recommendations are associated with our findings involving unreferred cost reports and cost reports that had been referred but whose outlier payments had not been reconciled; there are financial impacts and dollar amounts associated with each of these recommendations. Our last three recommendations are procedural in nature and do not have associated financial impacts or dollar amounts.

Auditee Comments

CGS did not directly agree or disagree with our last three recommendations, which are procedural. For our fifth and sixth recommendations, CGS stated that it had standardized work instructions and control procedures and added that it "… continues to refer outlier reconciliations to CMS timely and has not identified any cases in which a proper reconciliation was not performed." For our final recommendation, CGS said that it had properly completed the reconciliation process "… on all cost report final settlements and submitted them timely, where applicable."

Office of Inspector General Response

Our findings and our responses to CGS's comments show that CGS's control procedures regarding cost report referral and its policies and procedures for reconciliation of outlier payments were not always adequate. Measures to strengthen these procedures would bring CGS into closer compliance with CMS policies and requirements regarding cost report referral and reconciliation of outlier payments. These measures would also contribute to the successful implementation of our final recommendation. We therefore maintain that all of our procedural recommendations remain valid and provide precise, focused, and actionable measures through which CGS, in concert with CMS, can address and resolve our findings.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 11	A-07-10-02775	04/23/15
National Heritage Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-05-11-00024	04/21/15
Cahaba Government Benefits Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-05-11-00019	03/30/15
Novitas Solutions, Inc. (Formerly Highmark Medicare Services, Inc.), Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-05-11-00023	03/27/15
First Coast Service Options, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-05-11-00022	03/27/15
National Government Services, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 8	A-05-14-00046	03/16/15
Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-07-10-02774	12/16/14
Wisconsin Physicians Service Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-07-10-02777	11/18/14
Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-07-11-02773	10/29/14
TrailBlazer Health Enterprises Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required	A-07-10-02776	06/10/14
The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance	A-07-10-02764	06/28/12

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether CGS 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.[23] If the cost reports had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and calculated the amounts due to Medicare or to providers.

We performed audit work in our Denver, Colorado, field office, from May 2011 to August 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 CGS 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 CGS officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed CGS'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 CGS's jurisdiction as of December 28, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that CGS had referred to CMS for reconciliation during our audit period;

[23] 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 cost report data from CMS's database for cost reports with fiscal-year ends during our audit period;

- 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[24] 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 CGS used the three different types of outlier payments specified by Federal regulations[25] (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;

- requested that CGS provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;[26]

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

- verified whether CGS 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 CGS did not recalculate the outlier payments:

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

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

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

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

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

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

- calculated accrued interest[27] 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 CGS officials on August 22, 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.

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

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

Table 1: Total Cost Reports and Amounts Due

Grand Total	Due to Medicare	Due to Provider
18 Cost Reports	$21,596,878	$2,054,252

Table 2: Cost Reports Not Referred (OIG Identified)

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		Past 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
Number of Cost Reports	0	0	1	2	3	3
Balance Due to Medicare	0	0	$227,844	$1,422,591	$1,650,435	$1,650,435
Interest Due to Medicare	0	0	51,312	408,888	460,200	460,200
Balance Due to Provider	0	0	0	0	0	0
Interest Due to Provider	0	0	0	0	0	0
Total Due to Medicare	**$0**	**$0**	**$279,156**	**$1,831,479**	**$2,110,635**	**$2,110,635**
Total Due to Provider	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Table 3: Cost Reports Referred (Medicare Contractor Identified)

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		Past 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
Number of Cost Reports	1	8	5	1	14	15
Balance Due to Medicare	$706,750	$12,254,561	$4,710,728	$399,331	$17,364,620	$18,071,370
Interest Due to Medicare	68,448	842,007	452,724	51,694	1,346,425	1,414,873
Balance Due to Provider	0	1,894,065	0	0	1,894,065	1,894,065
Interest Due to Provider	0	160,187	0	0	160,187	160,187
Total Due to Medicare	**$775,198**	**$13,096,568**	**$5,163,452**	**$451,025**	**$18,711,045**	**$19,486,243**
Total Due to Provider	**$0**	**$2,054,252**	**$0**	**$0**	**$2,054,252**	**$2,054,252**

APPENDIX D: AUDITEE COMMENTS

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January 5, 2015

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: CGS Response to Draft OIG Report entitled *CGS Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments (Report # A-07-13-02791)*

Dear Mr. Patrick J. Cogley,

CGS Administrators, LLC, the Part A/B and Home Health and Hospice Medicare Administrative Contractor for Jurisdiction 15, appreciates the opportunity to comment on the Office of Inspector General's draft report entitled *CGS Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments (Report # A-07-13-02791).* CGS strongly disagrees with the title and the substance of the report. CGS requests that the CGS' name be removed from the title of this report because CGS was not the Contractor "since 2011" as is stated in the report. In addition, CGS did not have the responsibility for the cost reports reviewed and cited in this report until 10/17/11, the date that the contract transitioned from NGS to CGS. Of the 15 cost reports referred to CMS for outlier payments that qualified for reconcilitation, only 2 cost report referrals were the responsibility of CGS. CGS had no opportunity to influence actions taken on 13 of the 15 cost reports.

CGS does not concur with the findings in this report as they conflict with established guidance.

1. The issue of "No Referral" of three cost reports - The CMS Claims Processing Manual states the outlier reconciliation process should be completed at the time of final settlement of the Medicare cost report. *(See Chapter 3, Section 20.1.2.5 Reconciliation-"Under 42 CFR 412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at* ***FINAL*** *settlement of the cost reporting period during which the discharge occurred.");*

26

   a) Cost Report REDACT FYE 12/31/07- the final settlement was on hold by the outgoing contractor, National Government Services (NGS) pending the final SSI% s

[26] Office of Inspector General Note—The deleted text has been redacted because it is proprietary information.

release by CMS. All contractors were instructed by CMS to delay processing final settlements of Medicare cost reports requiring DSH payments until the SSI%'s (FY 2006 – 2009) were released. This delayed settlement of hospital cost reports until June 8, 2012 when CR 7814 was released. CGS properly referred the case to CMS on 10/2/2012.

b) Cost Reports REDACT FYE 1/31/07 and REDACT 12/31/04 were final settled by the outgoing contractor, National Government Services, on 6/30/08 and 3/20/06, respectively. NGS did not refer the cost reports timely to CMS in addition both final settlement dates and 3-year reopening limits had expired prior to the workload transitioning to CGS on 10/17/2011. Therefore, CGS is unable to take further action.

2. The issue of "No Reconciliation" for 15 cost reports –
   a) Two Cost Reports REDACT 02/28/2006 and REDACT 02/28/2007 were final settled by the outgoing contractor, National Government Services. NGS did not complete the reconciliations as noted and the 3-year reopening limit expired prior to the workload transitioning to CGS on 10/17/2011. Therefore, CGS is unable to take further action.
   b) Three Cost Reports REDACT 12/31/05, REDACT 12/31/2006, and REDACT 12/31/06 were pending for the release by CMS of DSH/SSI%s as noted above. The cost reports were subsequently reconciled once the SSI %'s were released by CMS.
   c) Eight Cost Reports REDACT 9/30/2006, REDACT 06/30/2005, REDACT 06/30/2006, REDACT 12/31/2004, REDACT 09/30/06, REDACT 09/30/2007, REDACT 12/31/2008 and REDACT 06/30/2009 were reconciled timely by National Government Services.
   d) Two Cost Reports REDACT 06/30/2007 and REDACT 06/30/2008 were reconciled timely by CGS on 3/20/12 after the transition of the contract from NGS to CGS. The delay in processing the reconciliations was due to problems with the FISS utility tool. Once the issue was corrected by CMS, the cost reports were finalized on 4/23/14 and 6/18/14, respectively.

In addition to requesting comments on the report, you ask that CGS state concurrence or nonconcurrence with each of the seven recommendations in the report. CGS has made comments to the following seven recommendations:

1. Review the 1 cost report that had not been settled and should have been referred to CMS for reconciliation but was not, take appropriate actions to refer the cost report, request CMS approval to recoup $279,156 in funds and associate interest from health care Cost Reprot, and refund that amount to the Federal Government.
   - Response: CGS concurs and referred the cost report to CMS on 10/2/12 after the SSI% for that year end was released by CMS. To date, CGS has not received a response from CMS.
2. Review the 2 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not; determine whether these cost reports may be reopened; and work with CMS or resolve $1,831,479 in funds and associated interest from health care providers that may be due to the Federal Government.

- Response: CGS does not concur with this recommendation; the outgoing contractor, NGS did not complete the reconciliation and the 3-year reopening limit expired prior to the workload transitioning to CGS on 10/17/2011. Therefore, CGS is unable to take further action.

3. Review the 13 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
   a) Reconcile the $18,260,020 in associated outlier payments due to the Federal Government (11 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare.
      - Response: All reports have been finalized, referred to CMS and/or pending receipt of final SSI%. (see attached document for dates submitted)
   b) Reconcile the $2,054,252 in associated outlier payments due from Medicare to providers (2 cost reports), finalize these cost reports, and return the funds to the providers;
      - Response: The cost reports for these two providers ([REDACT] FYE 6/30/06 and [REDACT] FYE 12/31/04) were finalized on 6/20/12.
4. Review the 1 cost report that had exceeded the 3-year reopening limit, was referred to CMS, and should have been reopened but was not; determine whether the cost report may be reopened; and work with CMS to resolved the $451,025 in funds and associated interest that may be due from a health care provider to the Federal Government.
   - Response: CGS does not concur with this recommendation; the outgoing contractor, NGS finalized the cost report on 1/23/07 and the 3-year reopening limit expired prior to the workload transitioning to CGS on 10/17/2011. Therefore, CGS is unable to take further action.
5. Continue to 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;
   - Response: CGS has standardized work instructions with appropriate control procedures for the outlier referral process in place.
6. Continue to 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;
   - Response: CGS has standardized work instructions for the outlier reconciliation process which are reviewed annually with changes approved by management., CGS continues to refer outlier reconciliations to CMS timely and has not identified any cases in which a proper reconciliation was not performed.
7. Review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.
   - Reponse: CGS has properly completed outlier reconciliatons on all cost report final settlements and submitted them timely, where applicable.

In summary, CGS Administrators, LLC is in compliance with the requirements surrounding the reconciliation of outlier payments and, has the proper policies and procedures in place to refer the completed reconcilitions to CMS in a timely manner. Should you have any additional questions, please feel to contact Jacqueline Yarbrough at 615.782.4671 or Jacqueline.Yarbrough@cgsadmin.com.

Sincerely,

John Kimball
Vice President, Operations