Department of Health and Human Services
Office of Inspector General
Office of Audit Services

October 2024 | A-06-24-05000

National Government Services, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers

REPORT HIGHLIGHTS

October 2024 | A-06-24-05000

National Government Services, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers

Why OIG Did This Audit

- Medicare providers are required to submit to their Medicare administrative contractors (MACs) annual cost reports, which are financial documents that convey the provider's costs associated with providing services to Medicare enrollees. MACs use them to determine the final amount of Medicare program reimbursement due providers for their cost reporting period (the final settlement of the cost report).
- MACs can audit a provider's cost report after performing a mandatory desk review to further verify compliance with the law, regulations, and Medicare manual instructions relating to the final settlement of the cost report.
- CMS's primary goal is for the MACs to arrive at correct final settlements of the cost report. If there is an error made in the final settlement, the cost report final settlement may be reopened and adjusted to correct for the error. We performed this audit of one MAC, National Government Services, Inc. (NGS), to determine whether NGS reopened and corrected cost report final settlements because of audit errors.

What OIG Found

NGS reopened 11 of 209 (5.3 percent) audited cost reports to correct the final settlements that contained obvious errors. These 11 audited cost reports required 12 reopenings because of human errors by NGS personnel.

- As a result of these 12 errors, the reopened cost reports resulted in corrected final settlements to providers totaling $344,794 in net overpayments (which consisted of $582,584 in overpayments and $237,790 in underpayments).
- The risk exists that delays in the finalization of audited cost reports could prevent some Medicare funds from being expended in the most efficient and effective ways.
- Auditors and supervisors required additional education on the criteria and audit requirements. NGS's procedures for review by supervisors did not detect the incorrect audit adjustments.

What OIG Recommends

We recommend that NGS develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements and develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect audit adjustments.

NGS agreed with both of our recommendations and described actions it has taken to address them.

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INTRODUCTION

WHY WE DID THIS AUDIT

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

A MAC, as part of its Medicare Integrity Program activities, can audit a provider's cost report after performing a mandatory desk review to further verify compliance with the law, regulations, and Medicare manual instructions relating to the determination of reimbursement amounts.[2] These amounts include graduate medical education (GME) payments, indirect medical education (IME) payments, disproportionate share hospital (DSH) payments, payments associated with bad debts, and certain other amounts, as well as cost-reimbursed items, such as reasonable costs claimed by cancer hospitals or critical access hospitals (CAHs).[3] At the conclusion of the MAC's audit, the MAC issues a Notice of Program Reimbursement (NPR) to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to Medicare. The Centers for Medicare & Medicaid Services' (CMS's) primary goal is for MACs to arrive at correct settlements of the cost report.[4] If there is an error made in the final settlement, the cost report final settlement can be reopened and adjusted to correct for the error.[5]

Some cost reports that have been audited and settled are later reopened to correct the final settlement. The MACs maintain supporting documents for the cost reports that they reopen and for the reasons for the reopenings. These supporting documents include information related to the monetary adjustments to correct the final settlements. MACs submit cost report-related information to CMS.

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

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

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

[4] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 60.5.

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

We performed this audit to determine whether National Government Services, Inc. (NGS), which currently has two MAC jurisdictions covering 10 States, reopened and corrected cost report final settlements because of audit errors.[6]

OBJECTIVE

Our objective was to determine whether, for the audited cost reports that NGS reopened to correct the final settlements, any of the audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by NGS**.**

BACKGROUND

Medicare Program

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

Medicare Cost Reports

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

Providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the MAC performs a tentative settlement, then performs a desk review of the cost report and conducts an audit, as appropriate, before final settlement.[7]

[6] On November 1, 2023, we issued a report to Noridian Healthcare Solutions titled *Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers* (A-06-22-05000).

[7] 42 CFR § 413.64(f)(2); *Provider Reimbursement Manual*, CMS Pub. No. 15-1, part 1, § 2408.2; *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.

Medicare Administrative Contractor Cost Report Reviews

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

MACs must conduct desk reviews of cost reports for all providers that file a Medicare cost report; exceptions are made for cost reports for hospices and for providers that have low or no Medicare utilization. A desk review is an analysis of the provider's cost report to evaluate its adequacy and completeness and determine the accuracy and reasonableness of the data contained in the cost report. Its purpose is to determine whether the cost report can be settled without an audit or whether an audit is necessary.[8] (This process does not include detailed verification and is designed to identify issues that may warrant additional review.) In contrast to the desk review, an audit is an examination of financial transactions that tests the provider's compliance with the law, regulations, and Medicare manual instructions.

In selecting cost reports to audit, the MAC uses its professional judgment in determining which providers represent the greatest risk of incorrect payment.[9] MACs perform audits in compliance with the Government Auditing Standards issued by the Comptroller General of the United States and use desk reviews and empirical knowledge of providers to define audit objectives and the scope and methodology to achieve those objectives.[10] If the MAC finds that claimed amounts in the cost report are not in accordance with the law, regulations, or Medicare manual instructions, it can create an audit adjustment to ensure that the cost report complies with those requirements.[11] All audit work performed is subject to supervisory review to ensure audit quality.[12] At the conclusion of the audit, the MAC then issues an NPR to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to the Medicare program.[13]

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

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

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

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

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

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

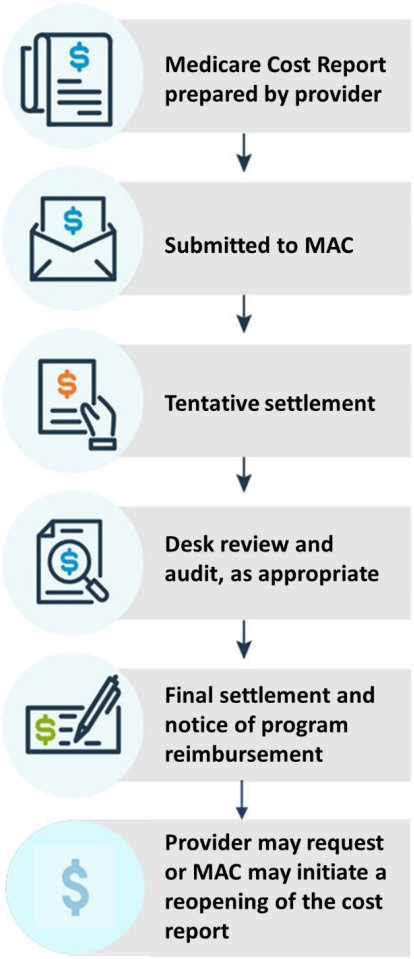
Cost Report Reopenings

A cost report final settlement may be reopened at the request of the provider or on the MAC's own initiative within 3 years of the date of the NPR to re-examine and adjust the final determination of the amount of total reimbursement due the provider (42 CFR § 405.1885).[14] The MAC's decision to reopen a settled cost report generally depends on whether new and material evidence has been submitted by the provider, an error was made during the final settlement process, or the settled cost report is found to be inconsistent with the law, regulations, and manual instructions (*Provider Reimbursement Manual*, part I, § 2931.2).

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

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

Figure: Medicare Cost Report Process



HOW WE CONDUCTED THIS AUDIT

We obtained information regarding 209 audited cost reports ending in fiscal years 2016 and 2017[15] for NGS's two MAC jurisdictions, J6 and JK, and determined whether they had been reopened. Of the 209 audited cost reports, NGS reopened 139 of them 1 or more times, for a total of 360 reopenings. Of the 360 cost report reopenings, we did not review 348 because they had been reopened and settled based on directions from CMS. We did not review reopened cost reports involving new information or for Medicare payments for new Medicaid

[15] We audited reopened cost reports for fiscal year end (FYE) 2016 and 2017 because there can be a significant delay, more than 3 years, between the cost report FYE and the reopened and revised final settlement to correct any errors associated with the MAC's audit. The figure on this page depicts the Medicare cost report submission, review, settlement (tentative and final), and reopening process.

patient days or new patient days for both Medicare and Supplemental Security Income (SSI).[16] We also did not review reopened cost reports that were outside the scope of this audit (Other Matters), were not caused by NGS, or were not settled during our review period. For the remaining 12 cost report reopenings, we obtained workpapers, audit adjustments, and final settlement summaries to identify whether the provider requested a reopening or NGS initiated the reopening, the reasons for the reopening, and the effect of the corrected final settlement.

When applicable, NGS officials furnished, and we reviewed, a description of the reasons the audited cost reports were reopened to correct final settlements that contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions.

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

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

FINDING

ELEVEN REOPENED COST REPORTS INVOLVED OBVIOUS ERRORS BY NATIONAL GOVERNMENT SERVICES, INC.

NGS reopened 11 of 209 (5.3 percent) audited cost reports, 1 more than once, for a total of 12 reopenings, to correct the final settlements that contained obvious errors by NGS personnel. Some of these errors involved omitting, misreporting, or miscalculating audit adjustments. Below are two examples of reopening adjustments for obvious errors in cost report final settlements.

According to NGS, it reopened one of the final settled cost reports because NGS did not reduce payments for hospitalizations associated with hospital-acquired conditions (HACs). When patients contract HACs, which could be postoperative, infections or pressure ulcers, while at the hospital, CMS may reduce payments by 1 percent. NGS did not apply an HAC reduction and reopened this cost report to show that the provider is subject to the HAC reduction. Adjustments in the reopening of the final settlement corrected the overpayment of $291,538 to this provider.

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

According to NGS, for another cost report, it reopened the final settled cost report on its own initiative because its audit (1) did not include an adjustment to allow payment for certain bad debts and (2) the low-income patient, supplemental security income ratio was reported on an incorrect worksheet. Reopening adjustments of the final settlement corrected the underpayment of $115,180 to this provider.

NGS officials stated that staff receive information about the specific errors through emails and team meetings, that review checklists are updated, and that additional reviews may be implemented. These errors occurred because NGS's procedures for review by both auditors and supervisors did not detect the incorrect or missing audit adjustments.

As a result of these 12 errors in the 11 cost reports, the reopened cost reports resulted in corrected final settlements to providers totaling $344,794 in net overpayments (which consisted of $582,584 in overpayments and $237,790 in underpayments). Moreover, although an analysis of time delays was not part of our methodology for this audit, the risk exists that delays in the finalization of audited cost reports could prevent some Medicare funds from being expended in the most efficient and effective ways.

Appendix B provides the details of the audit adjustment errors, including NGS's descriptions of why the errors occurred, information on specific Medicare requirements, and identification of which entity detected the error.

RECOMMENDATIONS

We recommend that National Government Services, Inc.:

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

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

OTHER MATTERS

During its audit of three cost reports, NGS adjusted Medicare Advantage days with the "Days" section of the Provider Statistical and Reimbursement Report (PS&R),[17] which was in accordance with CMS policy.[18] Subsequent to the audit of the three cost reports, on June 6, 2018, a PS&R workgroup determined the "Days" section of the PS&R was inaccurate. The PS&R

[17] "Days" is reported in Worksheet S-3 of the Medicare cost report, *Provider Reimbursement Manual*, CMS Pub. No. 15-2, § 4005.1.

[18] Change Request 11642 (Dec. 14, 2020).

workgroup[19] decided to use the "Accommodations" units section of the PS&R to adjust Medicare Advantage days. NGS reopened the audited cost reports to adjust Medicare Advantage days per the "Accommodations" units section of the PS&R. This was not in accordance with CMS policy. We consider the audited cost report final settlements as accurate and consider the reopenings as an error because it was not in accordance with CMS policy.

In response to another MAC's request for technical direction on this issue (Technical Direction Request Number 2022-20), CMS stated:

> Several MACs have subsequently noted that the PS&R user group minutes are for informational purposes only and are not intended for use as Medicare Program policy. Therefore, the MACs have requested technical direction from CMS.
>
> CMS agrees that the PS&R user group minutes are for informational purposes only and are not intended for use as Medicare Program policy. Therefore, MACs (and HFS[20]) should have never started using accommodations units in lieu of Medicare days several years ago. CMS is instructing MACs to use Medicare Days for the settlement of all open cost reports.

CMS states in its *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 30.2:

> Your [the MAC] authority does not extend to determining whether program policies and procedures are appropriate or should be applied in a given circumstance. Rather, your responsibility is to enforce such policies and procedures. Take corrective action where noncompliance exists.

NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In written comments on our draft report, NGS agreed with our recommendations and described corrective actions that it had taken to address them. Specifically, for the first recommendation, NGS said that it continually recalibrates its procedures and processes to address areas of improvement based on its Internal Quality Control (IQC) process or through external audits performed by CMS. NGS added that it conducts monthly technical meetings to address any IQC or external findings and educates staff on updates to the cost report and to its policies and procedures. NGS also stated that it has enhanced its new staff onboarding efforts to provide training and assign a mentor to answer questions and guide new staff.

For the second recommendation, NGS stated that it has instituted a checklist to be performed on all desk reviews and audits at the Level 1 and Level 2 review processes to ensure the proper recording of adjustments from the workpapers to the adjustment report of the final cost report

[19] PS&R User Group Teleconference – Minutes (Aug. 29, 2018).

[20] Health Financial Systems is a computer software company specializing in cost reports.

are accurately reported. NGS also stated that it has implemented an additional Level 3 review by the Lead Auditor before the final settlement of cost reports.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We obtained information regarding 209 audited cost reports ending in fiscal years 2016 and 2017 for NGS's two MAC jurisdictions (J6 and JK) and determined whether they had been reopened. Of these 209 audited cost reports, NGS reopened 139 of them, 1 or more times, for a total of 360 cost report reopenings. Of the 360 cost report reopenings, we did not review 348 because they had been reopened and settled based on directions from CMS, were for new and material evidence, were outside the scope of this audit (Other Matters) or not caused by NGS, or were not settled during our review period. The removal of these cost report reopenings left 12 cost report reopenings for further review.

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

We performed audit work from October 2023 through September 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and Medicare manual instructions;
- obtained and reviewed information from NGS related to audited cost reports for fiscal years 2016 and 2017;
- removed 348 cost report reopenings from our scope of 360 reopenings because the cost reports:
    - involved reopenings based on CMS direction (246 cost report reopenings), and they were not related to the quality and performance of NGS's audits,
    - had been reopened based on new and material evidence claimed for the first time in the reopening (74 cost report reopenings) and therefore had no bearing on the quality and performance of NGS's audits of the initial cost reports,
    - involved reopenings for new and material evidence because the providers claimed new patient days related to Medicaid and SSI (footnote 16) (21 cost report reopenings),

- involved reopenings for obvious errors but were outside the scope of this audit because NGS did not cause the errors (1 cost report reopening), and the final settlement based on the PS&R (Other Matters) was not in error (3 cost report reopenings) (4 total cost report reopenings), and

- had been reopened for obvious errors but were not revised or settled at the end of our fieldwork (3 cost report reopenings);

- for the remaining 12 audited cost report reopenings, obtained and reviewed the reopening documentation, including reasons for the reopening, root causes of the errors, and effect of the reopened final settlements;

- obtained and reviewed NGS's policies and procedures for conducting audits, the reopening process and supervisory review;

- determined the adequacy of supervisory review by NGS to detect errors in the audited cost reports; and

- discussed the results of our audit with NGS officials.

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

APPENDIX B: AUDIT ERROR DETAILS

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by NGS on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
1	NGS omitted a desk review adjustment to allow payment for certain bad debts.	Due to human error, auditor/ reviewer did not detect the missed adjustment.	Allowable bad debts attributable to the deductibles and coinsurance amounts are reimbursable by Medicare (42 CFR § 413.89; CMS Pub. 15-1, chapter 3).	NGS	($38,149)
2	NGS misreported the locality-adjusted per resident amount (PRA).	Due to human error, the auditor/ reviewer did not detect incorrect adjustment.	GME payments attributable to additional full-time equivalent (FTE) residents are calculated using the locality-adjusted national average PRA (42 CFR § 413.77; CMS Pub 15-2, § 4034).	NGS	(19,777)
3	NGS miscalculated reimbursement to certain rural hospitals.	Due to human error, the auditor/ reviewer did not detect incorrect adjustment.	Section 3123 and 10313 of the Patient Protection and Affordable Care Act, and Section 15003 of the 21st Century Cures Act, extended the Rural Community Hospital Demonstration program and expanded the maximum number of participating hospitals with low density populations. CMS Change Request 10373 (December 29, 2017) provided the payment methodology for the demonstration.	NGS	51,005

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by NGS on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
4	NGS misreported electronic health record (EHR) data related to a CAH.	Due to human error, the auditor/ reviewer did not detect incorrect adjustment.	A qualifying CAH receives an incentive payment for the reasonable costs of purchasing certified EHR technology in a cost reporting period during a payment year. If a CAH is not a qualifying CAH for the applicable EHR reporting period, then the reasonable costs of providing services to its inpatients are adjusted by an applicable percentage (42 CFR §§ 413.70(a)(5) and 413.70(a)(6); CMS Pub 15-2, § 4004.1).	NGS	0
5	NGS omitted adjustments related to maintenance/ repair and rent/lease expenses in the settled cost report.	Due to human error, the auditor/ reviewer did not detect missed adjustment.	Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on approved method of cost finding (42 CFR § 413.24). Providers must maintain sufficient financial records and statistical data for proper determination of costs payable under the program (42 CFR § 413.20). Worksheet A-6 provides for the reclassification of certain costs to effect proper cost allocation under cost finding (CMS Pub. 15-2, §	NGS	(41,444)

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by NGS on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			4014). Worksheet B, part 1 reports general service costs based on approved cost finding methods (CMS Pub. 15-2, § 4020).		
6	NGS misreported the provider's geographical reclassification from Urban to Rural.	Due to human error, the auditor/ reviewer did not detect missed adjustment.	A hospital that reclassifies as rural may receive an adjustment to its IME FTE cap (70 Fed. Reg. 47278, 47434-47457 (Aug. 12, 2005)). Worksheets S-2 part 1, E part A, and L part 1 calculate reimbursement due to geographical reclassification (CMS Pub. 15-2, §§ 4004.1, 4030.1, and 4064.1).	NGS	(4,590)
7	NGS misreported the number of FTEs from the provider's affiliation agreements.	Due to human error, the auditor/ reviewer did not detect incorrect adjustment.	A GME affiliation agreement is between two or more hospitals that meet certain FTE rotation requirements (42 CFR § 413.75(b)). Hospitals that are part of the same GME-affiliated group may elect to apply the FTE resident cap on an aggregate basis (42 CFR § 413.79(c)(2)(iv)). A hospital may receive a temporary adjustment to its FTE cap to reflect residents added or subtracted because the hospital is participating in	NGS	(8,103)

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by NGS on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			a Medicare GME-affiliated group (42 CFR § 413.79(f)). If the provider increased its current year FTE cap and count due to an affiliation agreement, identify the lower of the difference between the current year numerator and the prior year numerator and the number by which the FTE cap increased per the affiliation agreement. Then, add the lower of these two numbers to the prior year's numerator (CMS Pub 15-2, § 4030.1). Worksheet E-4 is used to calculate GME payment (CMS Pub. 15-2, § 4034).		
8	NGS misreported the number of Medicare days from the PS&R.	Due to human error, the auditor/ reviewer did not detect the incorrect adjustments.	Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of operating costs, capital-related costs, and additional costs as applicable (42 CFR § 412.110). The provider must furnish such information to the contractor as may be	NGS	1,573

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by NGS on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			necessary to— (i) Assure proper payment by the program, (ii) Receive program payments; and (iii) Satisfy program overpayment determinations (42 CFR § 413.20; CMS Pub. 15-1, § 2408.4).		
9	NGS misreported the IME FTE count as an affiliated program.	Due to human error, the auditor/ reviewer did not detect the incorrect adjustment.	A GME affiliation agreement is between two or more hospitals that meet certain FTE rotation requirements (42 CFR § 413.75(b)). If the provider increased its current year FTE cap and count due to an affiliation agreement, identify the lower of the difference between the current year numerator and the prior year numerator and the number by which the FTE cap increased per the affiliation agreement. Then, add the lower of these two numbers to the prior year's numerator (CMS Pub. 15-2, § 4030.1).	NGS	238,468
10	NGS misreported an HAC reduction.	Due to human error, the auditor/ reviewer did not detect	An HAC is a condition that an individual acquires during a stay in a hospital paid under the inpatient prospective payment	NGS	291,538

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by NGS on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
		missing adjustment.	system (42 CFR § 412.170; CMS Pub. 15-2, § 4030.5 [sic]).		
11	NGS misreported (1) FTEs direct GME cap, (2) end-stage renal disease (ESRD) reimbursement, and (3) ESRD home training treatments and payment.	Due to human error, the auditor/ reviewer did not detect incorrect adjustments.	If a hospital's reference resident level is less than its applicable FTE resident cap, the hospital's cap is reduced by 75 percent of the difference between the applicable FTE resident cap and the reference resident level (42 CFR § 413.79(c)(3)). Worksheet E-4 is used to calculate direct GME for hospitals that receive an adjustment to their resident caps (CMS Pub 15-2, § 4034). Worksheet E-1 is used to report Medicare interim payments paid by the contractor (CMS Pub 15-2, § 4031.1). Worksheet I-4 is used to record dialysis treatment costs (CMS Pub. 15-2, § 4051).	NGS	(10,547)
12	NGS (1) omitted a desk review adjustment to allow payment for certain bad debts and (2) misreported low-income patient (LIP), SSI	Due to human error, the auditor/ reviewer did not detect missing and incorrect adjustments.	Allowable bad debts attributable to the deductibles and coinsurance amounts are reimbursable by Medicare (42 CFR § 413.89; CMS Pub. 15-1, chapter 3). Report the LIP SSI ratio on E-3, part III, Rehab, line 2	NGS	(115,180)

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by NGS on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
	ratio.		part III (CMS Pub. 15-2, § 4033.3).		

* As reported by NGS. Subject to minor edits by Office of Counsel to the Inspector General.

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

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

APPENDIX C: NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

October 4, 2024

Report Number: A-06-24-05000

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

Dear Ms. Wheeler,

As requested, National Government Services (NGS) provides its written comments in response to the draft recommendations the Office of Inspector General made to NGS in draft report *National Government Services, Inc, Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers*, A-06-24-05000. NGS concurs with the recommendations made by the OIG.

- Draft Recommendation: Develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements.

  NGS Response: Concur. NGS is continually recalibrating our procedures and processes to address areas for improvement that are discovered either through our Internal Quality Control (IQC) process or through external audits (e.g., QASP) required or performed by CMS. NGS has implemented the following enhancements to our processes:

  - Monthly technical meetings are held to address any IQC findings or external audit findings and to educate staff on updates to the cost report and to our policies and procedures;
  - Enhanced onboarding efforts have been initiated to ensure new staff receive a consistent and thorough introduction to Medicare cost report auditing; and
  - Following the training, new staff are assigned a mentor to answer questions and guide the new auditor as they begin to work on their assignments.

- Draft Recommendation: Develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect audit adjustments

  NGS Response: Concur. NGS has instituted a checklist to be performed on all desk reviews and audits at the Level 1 and Level 2 review process. This ensures that certain steps such as the proper recording of audit adjustments from the workpapers to the adjustment report to the final cost report are accurately being reported. NGS has also implemented a Level 3 review which is an additional review by the Lead Auditor prior to final settlement of the cost report.

  Although the number of reopening errors make up 5.3% of the audits completed by NGS during the cost reports fiscal years ending 2016 and 2017, we agree with the OIG's direction

national government SERVICES

to develop and deliver additional education and enhance procedures to reduce and or eliminate the errors that result in incorrect payments.

Sincerely,

/Jared Griep/

Jared Griep
Jurisdiction 6 Program Manager

Jared Griep Digitally signed by Jared Griep Date: 2024.10.04 11:03:42 -05'00'

Thomas C. Hansen
Jurisdiction K Program Manager

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does it Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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