Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

NOVITAS SOLUTIONS, INC. (FORMERLY HIGHMARK MEDICARE SERVICES, INC.), DID NOT ALWAYS REFER MEDICARE COST REPORTS AND RECONCILE OUTLIER PAYMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

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EXECUTIVE SUMMARY

Novitas Solutions, Inc. did not always refer cost reports whose outlier payments qualified for reconciliation to the Centers for Medicare & Medicaid Services. The financial impact of these unreferred cost reports was $11.5 million that should be recouped from health care providers and returned to Medicare. In addition, Novitas 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. Since 2008, one such contractor, Highmark Medicare Services, Inc., now Novitas Solutions, Inc. (Highmark Medicare Services, Inc. and Novitas Solutions, Inc. are collectively referred to as "Novitas" throughout this report), has been the Medicare contractor for Jurisdiction 12, which comprises Delaware, the District of Columbia, Maryland, New Jersey, and Pennsylvania.

The objectives of this review were to determine whether Novitas (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 Novitas 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 43 cost reports with outlier payments that qualified for reconciliation, Novitas referred 29 cost reports to CMS in accordance with Federal guidelines. However, Novitas did not refer 14 cost reports that should have been referred to CMS for reconciliation. Of these 14 cost reports, 5 cost reports had not been settled and should have been referred to CMS for reconciliation. As of December 31, 2011, the difference between the outlier payments associated with these five cost reports and the recalculated outlier payments totaled $11,477,187. We refer to this difference as "financial impact." The nine remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. We calculated that the financial impact of the outlier payments associated with those nine cost reports totaled at least $11,642,706 that may be due to Medicare (eight cost reports) and $652,737 that may be due to a provider (one cost report).

Of the 29 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Novitas had reconciled the outlier payments associated with 27 cost reports by December 31, 2011. However, Novitas had not reconciled the outlier payments associated with the remaining two cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with one of the two cost reports that were referred but not reconciled was $1,414,588 that was due from Medicare to a provider. For the remaining cost report that exceeded the 3-year reopening limit and should have been reconciled, the financial impact of the outlier payments was $2,245,825 that may be due to Medicare.

WHAT WE RECOMMEND

We recommend that Novitas:

- review the five cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup $11,477,187 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

- review the nine 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 at least $11,642,706 in funds and associated interest from health care providers that may be due to the Federal Government (eight cost reports) and

    - resolve $652,737 in funds and associated interest that may be due to a provider (one cost report);

- review the cost report that was referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the $1,414,588 in associated outlier payments due from Medicare to a provider, finalize that cost report, and return the funds to the provider;

- review the cost report that had exceeded the 3-year reopening limit, was referred to CMS, and should have been reopened but was not, determine whether this cost report may be reopened, and work with CMS to resolve the $2,245,825 in funds and associated interest that may be due to the Federal Government;

- ensure that control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit; 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, Novitas concurred with all of our recommendations and described corrective actions that it had taken or planned to take. Regarding the cost reports that had exceeded the 3-year reopening limit, Novitas stated that these cost reports could not be reopened.

After reviewing Novitas's comments, we maintain that all of our findings and recommendations are valid. Regarding the 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."

TABLE OF CONTENTS

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 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.[3] Since 2008, one such contractor, Highmark Medicare Services, Inc., now Novitas Solutions, Inc.[4] (Highmark Medicare Services, Inc. and Novitas Solutions, Inc. are collectively referred to as "Novitas" throughout this report), has been the Medicare contractor for Jurisdiction 12, which comprises Delaware, the District of Columbia, Maryland, New Jersey, and Pennsylvania.

OBJECTIVES

Our objectives were to determine whether Novitas (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.[5]

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[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] Appendix A contains a list of related Office of Inspector General reports.

[4] Effective January 1, 2012, Diversified Service Options, Inc., a wholly-owned subsidiary of Blue Cross and Blue Shield of Florida Inc., acquired Highmark Medicare Services, Inc., from its parent company, Highmark, Inc. As a result, Highmark Medicare Services, Inc., changed its name to Novitas Solutions, Inc.

[5] 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.

BACKGROUND

Medicare and Outlier Payments

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

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

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

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

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

To qualify for outlier payments, a claim must have costs that exceed a CMS-established cost threshold. Costs are calculated by multiplying covered charges by a hospital-specific CCR. Because a hospital's actual CCR for any given cost-reporting period cannot be known until final settlement of the cost report for that year, the Medicare contractors calculate and make outlier payments using the most current information available when processing a claim. For discharges occurring on or after October 1, 2003, the CCR applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, 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 (FY) ends. CMS instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report (*Provider*

Reimbursement Manual, part 2, § 140). After accepting a cost report,[6] the Medicare contractor completes its preliminary review and may issue a tentative settlement to the hospital. In general, Medicare contractors perform tentative settlements to make partial payments to hospitals owed Medicare funds (although in some cases a tentative settlement may result in a payment from a hospital to Medicare). This practice helps ensure that hospitals are not penalized because of possible delays in the final settlement process.

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

The Medicare contractor reviews the cost report and may audit it before final settlement. If a cost report is audited, the Medicare contractor incorporates any necessary adjustments to identify reimbursable amounts and finalize Medicare reimbursements due from or to the hospital.[7] 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[8] 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.

[6] 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.

[7] 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.

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

CMS Changes in the Hospital Outlier Payment Reconciliation Methodology

Outlier Payment Reconciliation

CMS developed new outlier regulations[9] and guidance in 2003 after reporting that, from Federal FYs 1998 through 2002, it paid approximately $9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.[10, 11] The 2003 regulations intended to ensure that outlier payments were limited to extraordinarily high-cost cases and that final outlier payments reflected an accurate assessment of the actual costs the hospital had incurred. Medicare contractors were to refer hospitals' cost reports to CMS for reconciliation so CMS could correctly re-price submitted claims and allow Medicare contractors to settle cost reports.[12]

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 differ from 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[13] provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until

[9] 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).

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

[11] 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.

[12] 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.

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

April 1, 2011. In CMS Transmittal 2111,[14] 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[15] before April 1, 2011. Further, CMS was to grant approval for Medicare contractors to perform reconciliations for those hospitals with open cost reports. Contractors were then to reconcile, by October 1, 2011, outlier claims that had been flagged before April 1, 2011.

CMS Lump Sum Utility Used in Outlier Recalculation

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

Cost Reports on Hold

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

HOW WE CONDUCTED THIS REVIEW

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Novitas 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

[14] 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).

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

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

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

Appendix B contains details of our audit scope and methodology.

FINDINGS

Of 43 cost reports with outlier payments that qualified for reconciliation, Novitas referred 29 cost reports to CMS in accordance with Federal guidelines. However, Novitas did not refer 14 cost reports that should have been referred to CMS for reconciliation. Of these 14 cost reports, 5 cost reports had not been settled and should have been referred to CMS for reconciliation. As of December 31, 2011, the difference between the outlier payments associated with these five cost reports and the recalculated outlier payments totaled $11,477,187. We refer to this difference as "financial impact."[16] The nine remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. We calculated that the financial impact of the outlier payments associated with those nine cost reports totaled at least $11,642,706 that may be due to Medicare (eight cost reports) and $652,737 that may be due to a provider (one cost report).

Of the 29 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Novitas had reconciled the outlier payments associated with 27 cost reports by December 31, 2011. However, Novitas had not reconciled the outlier payments associated with the remaining two cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with one of the two cost reports that were referred but not reconciled was $1,414, 588 that was due from Medicare to a provider. For the remaining cost report that exceeded the 3-year reopening limit and should have been reconciled, the financial impact of the outlier payments was $2,245,825 that may be due to Medicare.

See Appendix C for a summary of the status of the 43 cost reports with respect to referral and reconciliation, as well as the associated dollar amounts due to Medicare or to providers.

[16] 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.

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.

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 43 cost reports with outlier payments that qualified for reconciliation, Novitas referred 29 cost reports to CMS in accordance with Federal guidelines. However, Novitas did not refer 14 cost reports that should have been referred to CMS for reconciliation.

Cost Reports Within the 3-Year Reopening Limit

Of the 14 cost reports that Novitas did not refer to CMS for reconciliation, 5 had not been settled and should have been referred to CMS for reconciliation. Because Novitas 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 these five cost reports. As of December 31, 2011, the financial impact of the outlier payments associated with these five unreferred cost reports totaled $11,477,187 that was due to Medicare.

Cost Reports Outside the 3-Year Reopening Limit

Of the 14 cost reports that Novitas did not refer to CMS for reconciliation, the remaining 9 cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation.

Novitas did not refer six cost reports to CMS because Novitas had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified; were referred to CMS; and, if necessary, were reopened before the 3-year reopening limit. As a result of the inadequacy of these control procedures, Novitas did not perform the reconciliation test to identify and refer six cost reports that qualified for reconciliation.

For the remaining three cost reports, the Medicare contractor previous to Novitas did not correctly perform the reconciliation tests and erroneously concluded that these cost reports did not meet the criteria for reconciliation. The cost reports were brought to final settlement without their outlier payments being reconciled. Because the cost reports were settled and the 3-year reopening limit had expired at the time of the providers' transition to Novitas, Novitas was unable to reconcile the outlier payments associated with these three cost reports.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these nine cost reports totaled at least $11,642,706 that may be due to Medicare (eight cost reports) and $652,737 that may be due to a provider (one cost report).

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 29 referred cost reports whose outlier payments qualified for reconciliation, Novitas reconciled the outlier payments associated with 27 cost reports by December 31, 2011. However, Novitas did not reconcile the outlier payments associated with two cost reports by December 31, 2011.

Cost Report Within the 3-Year Reopening Limit

Of the two referred cost reports whose outlier payments qualified for reconciliation, one had not been settled within the 3-year reopening limit; the outlier payments associated with this cost report should have been reconciled. As of December 31, 2011, this cost report was correctly referred but was still awaiting CMS approval to reconcile the outlier payments. CMS bore principal responsibility for this delay.[17]

For this cost report whose outlier payments Novitas did not reconcile by December 31, 2011, the financial impact of the outlier payments was $1,414,588 that was due from Medicare to a provider.

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

Cost Report Outside the 3-Year Reopening Limit

Of the two referred cost reports whose outlier payments qualified for reconciliation, the remaining 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. Novitas stated that CMS instructed Novitas to settle the cost report because CMS did not have any procedures in place to accomplish outlier reconciliation at the time of the cost report referral. CMS bore principal responsibility for the outlier payments associated with this cost report not being reconciled.

For this cost report which exceeded the 3-year reopening limit and whose outlier payments Novitas did not reconcile by December 31, 2011, the financial impact of the outlier payments was $2,245,825 that may be due to Medicare.

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with the five unreferred cost reports that were within the 3-year reopening limit was $11,477,187 that was due to Medicare. These cost reports should have been referred to CMS for reconciliation but were not and were also not reconciled even though their outlier payments qualified for reconciliation.

Also as of December 31, 2011, the financial impact of the outlier payments associated with the nine 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 $11,642,706 that may be due to Medicare (eight cost reports) and $652,737 that may be due to a provider (one cost report). Therefore, the net financial impact to Medicare of the nine unreferred cost reports that exceeded the 3-year reopening limit was at least $10,989,969.

In addition, for the referred cost report that was within the 3-year reopening limit and whose outlier payments Novitas did not reconcile by December 31, 2011, the financial impact of those outlier payments was $1,414,588 that was due to a provider.

Finally, for the referred cost report that exceeded the 3-year reopening limit and whose outlier payments Novitas did not reconcile by December 31, 2011, the financial impact of those outlier payments was $2,245,825 that may be due to Medicare.

RECOMMENDATIONS

We recommend that Novitas:

- review the five cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup $11,477,187 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

- review the nine 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 at least $11,642,706 in funds and associated interest from health care providers that may be due to the Federal Government (eight cost reports) and

    - resolve $652,737 in funds and associated interest that may be due to a provider (one cost report);

- review the cost report that was referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the $1,414,588 in associated outlier payments due from Medicare to a provider, finalize that cost report, and return the funds to the provider;

- review the cost report that had exceeded the 3-year reopening limit, was referred to CMS, and should have been reopened but was not, determine whether this cost report may be reopened, and work with CMS to resolve the $2,245,825 in funds and associated interest that may be due to the Federal Government;

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

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

AUDITEE COMMENTS

In written comments on our draft report, Novitas concurred with all of our recommendations and described corrective actions that it had taken or planned to take.

Regarding the cost reports that had exceeded the 3-year reopening limit (our second and fourth recommendations), Novitas stated that these cost report could not be reopened.

Novitas's comments appear in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that all of our findings and recommendations are valid.

With respect to the cost reports associated with our second and fourth recommendations, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "similar fault." Specifically, 42 CFR § 405.1885(b)(3) provides that a Medicare payment contractor (e.g., Novitas) may reopen an initial determination *at any time* if the determination was procured by

fraud or similar fault. For example, a Medicare payment contractor may reopen a cost report after finding 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 as noted in this report, 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 and fourth recommendations and recognize that ultimately, CMS as the cognizant Federal agency has the authority to decide how to resolve the recommendations in this audit report. Accordingly, we continue to recommend that Novitas determine whether the providers associated with these cost reports procured Medicare funds by "similar fault" and work with CMS to resolve its $13,235,794 ($11,642,706 - 652,737 + 2,245,825) in outlier payments.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-07-10-02774	12/16/2014
Wisconsin Physicians Service Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-07-10-02777	11/18/2014
Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	A-07-11-02773	10/29/2014
Trailblazer Health Enterprises Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required	A-07-10-02776	6/10/2014
The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance	A-07-10-02764	6/28/2012

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 Novitas 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.[18] 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 Chicago, Illinois, regional office from November 2010 to July 2014.

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 Novitas 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 Novitas officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed Novitas' 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 Novitas' jurisdiction as of November 4, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that Novitas had referred to CMS for reconciliation during our audit period;
- obtained the cost report data from CMS's database for cost reports with FY ends during our audit period;

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

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

- determined which cost reports qualified for reconciliation by:

    - using the information in a CMS database to identify acute-care and long-term-care cost reports that had greater than $500,000 in outlier payments[19] 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 Novitas used the three different types of outlier payments specified by Federal regulations[20] (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;

- requested that Novitas provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;[21]

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

- verified whether Novitas 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 the cost report that qualified for outlier reconciliation but for which Novitas did not recalculate the outlier payments:

    - obtained the detailed Provider Statistical & Reimbursement reports from Novitas;

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

    - recalculated the outlier payment amounts using the actual CCR; and

    - calculated accrued interest[22] as of December 31, 2011;

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

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

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

[22] We calculated interest by referring to the method used in the Claims Processing Manual, § 20.1.2.6.

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

- provided the results of our review to Novitas officials on March 4, 2014.

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 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
43 Cost Reports	**$47,718,850**	**$4,981,927**

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	5	0	9	14	14
Balance due to Medicare	$0	$9,171,804	$0	$8,689,110	$17,860,914	$17,860,914
Interest due to Medicare	0	2,305,383	0	2,953,596	5,258,979	5,258,979
Balance due to provider	0	0	0	514,907	514,907	514,907
Interest due to provider	0	0	0	137,830	137,830	137,830
Total due to Medicare	**$0**	**$11,477,187**	**$0**	**$11,642,706**	**$23,119,893**	**$23,119,893**
Total due to provider	**$0**	**$0**	**$0**	**$652,737**	**$652,737**	**$652,737**

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	27	1	0	1	2	29
Balance due to Medicare	$20,667,388	$0	$0	$1,990,215	$1,990,215	$22,657,603
Interest due to Medicare	1,685,744	0	0	255,610	255,610	1,941,354
Balance due to provider	2,646,445	1,068,965	0	0	1,068,965	$3,715,410
Interest due to provider	268,157	345,623	0	0	345,623	613,780
Total due to Medicare	**$22,353,132**	**$0**	**$0**	**$2,245,825**	**$2,245,825**	**$24,598,957**
Total due to provider	**$2,914,602**	**$1,414,588**	**$0**	**$0**	**$1,414,588**	**$4,329,190**

NOVITAS
SOLUTIONS

Sandy Coston
CEO
Novitas Solutions, Inc.
Sandy.Coston@dsocorp.com

January 9, 2015

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

RE: Report Number **A-05-11-00023,** Novitas Solutions Inc. (Formerly Highmark Medicare Services, Inc.), Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments

Dear Ms. Fulcher:

Novitas Solutions, Inc. (Novitas) has received the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled, "Novitas Solutions Inc. (Formerly Highmark Medicare Services, Inc.), Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments" and reviewed the recommendations. Novitas appreciates the opportunity to review and provide comments prior to the release of the final report.

In the draft report, the OIG outlined six recommendations that Novitas has addressed as follows. Novitas has referenced each of these recommendations and numbered them accordingly. While these issues occurred under Highmark Medicare Services, Inc., Novitas acknowledges full responsibility to resolve them, as outlined below.

Recommendation #1: Review the five cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup $11,477,187 in funds and associated interest from health care providers, and refund that amount to the Federal Government.

Response #1: Novitas Concurs - The five cost reports with a reopening that had not been settled were referred to CMS for reconciliation. Once approval from CMS is received, the reconciliation will be processed and the cost reports will be finalized to recoup and return any funds and associated interest.

Recommendation #2: Review the nine 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 at least $11,642,706 in funds and associated interest from health care providers that may be due to the Federal Government (eight cost reports) and
- resolve $652,737 in funds and associated interest that may be due to a provider (one cost report).

532 Riverside Avenue, Jacksonville, Florida 32202
Tel: 904-791-8409
Fax: 904-361-0372

Response #2: Novitas Concurs – Novitas has reviewed these cost reports and determined that all nine have exceeded the three-year time limit per PRM-1-2931.A., and therefore, they cannot be reopened. CMS has confirmed this understanding.

Recommendation #3: Review the cost report that was referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the $1,414,588 in associated outlier payments due from Medicare to a provider, finalize that cost report, and return the funds to the provider.

Response #3: Novitas Concurs – This cost report has been referred to CMS for reconciliation. Once approval from CMS is received, the reconciliation will be processed and a reopening will be finalized to return any funds.

Recommendation #4: Review the cost report that had exceeded the 3-year reopening limit, was referred to CMS, and should have been reopened but was not, determine whether this cost report may be reopened, and work with CMS to resolve the $2,245,825 in funds and associated interest that may be due to the Federal Government.

Response #4: Novitas Concurs - Novitas has reviewed the cost report and determined that it exceeded the three-year time limit per PRM-1-2931.A., and therefore, it cannot be reopened. CMS has confirmed this understanding.

Recommendation #5: Ensure that control procedures are in place so 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 #5: Novitas Concurs – Novitas has revised the control procedures related to the Outlier Reconciliation process to ensure that all cost reports whose outlier payments qualify for reconciliation are correctly identified, referred, and if necessary, are reopened before the three year reopening limit.

Recommendation #6: 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.

Response #6: Novitas Concurs – Novitas has reviewed all cost reports submitted since the end of the OIG's audit period to ensure that those whose outlier payments qualified for reconciliation were referred and reconciled in accordance with Federal guidelines.

Again, Novitas appreciates the opportunity to review and provide comments prior to the release of the final report. If you have questions regarding our responses, please contact Mr. Gregory W. England at 904-791-8364.

Sincerely,

/Sandy Coston/

cc: Gregory England