Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORIDIAN HEALTHCARE SOLUTIONS, LLC, DID NOT ALWAYS REFER MEDICARE COST REPORTS AND RECONCILE OUTLIER PAYMENTS

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Office of Inspector General

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EXECUTIVE SUMMARY

Noridian Healthcare Solutions, LLC (Noridian), 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 at least $6.9 million that should be recouped from health care providers and returned to Medicare. In addition, Noridian 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, Noridian Healthcare Solutions, LLC (Noridian), is the Medicare contractor for Jurisdiction F (formerly known as Jurisdictions 2 and 3), which comprises Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

The objectives of this review were to determine whether Noridian (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 Noridian 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 21 cost reports with outlier payments that qualified for reconciliation, Noridian referred 11 cost reports to CMS in accordance with Federal guidelines. However, Noridian did not refer 10 cost reports that should have been referred to CMS for reconciliation. Of these, three cost reports 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 these three cost reports and (2) the recalculated outlier payments totaled at least $6,919,974. We refer to this difference as financial impact. The seven 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 seven cost reports totaled at least $17,667,277.

Of the 11 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Noridian had reconciled the outlier payments associated with 6 cost reports by December 31, 2011. However, Noridian had not reconciled the outlier payments associated with the remaining five cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with the five cost reports that were referred but not reconciled was at least $7,213,678.

WHAT WE RECOMMEND

We recommend that Noridian:

- review the three 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 $6,919,974 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

- review the seven 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 $17,667,277 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the five cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the $7,213,678 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare;

- 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;

- ensure that policies and procedures are in place so 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, Noridian concurred with all of our recommendations, described corrective actions that it had taken or planned to take, and provided information as to the status of certain cost reports that agreed with our own analysis of their status.

Regarding the cost reports that had exceeded the 3-year reopening limit, Noridian said that it could not reopen those cost reports because of CMS instructions.

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

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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 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, Noridian Healthcare Solutions, LLC (Noridian), is the Medicare contractor for Jurisdiction F (formerly known as Jurisdictions 2 and 3), which comprises Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

OBJECTIVES

Our objectives were to determine whether Noridian (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.

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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] 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, § 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 payment from a hospital to Medicare). This practice helps ensure that hospitals are not penalized because of possible delays in the final settlement process.

[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.

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 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

[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, § 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.

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 reports. Contractors were then to reconcile, by October 1, 2011, outlier claims that had been flagged before April 1, 2011.

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[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.

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 Noridian 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 A contains details of our audit scope and methodology.

FINDINGS

Of 21 cost reports with outlier payments that qualified for reconciliation, Noridian referred 11 cost reports to CMS in accordance with Federal guidelines. However, Noridian did not refer 10 cost reports that should have been referred to CMS for reconciliation. Of these, three cost reports 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 these three cost reports and (2) the recalculated outlier payments totaled at least

$6,919,974. We refer to this difference as financial impact.[14] The seven 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 seven cost reports totaled at least $17,667,277.

Of the 11 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Noridian had reconciled the outlier payments associated with 6 cost reports by December 31, 2011. However, Noridian had not reconciled the outlier payments associated with the remaining five cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with the five cost reports that were referred but not reconciled was at least $7,213,678.

See Appendix B for a summary of the status of the 21 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.

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).

[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 A.

COST REPORTS NOT REFERRED

Of 21 cost reports with outlier payments that qualified for reconciliation, Noridian referred 11 cost reports to CMS in accordance with Federal guidelines. However, Noridian did not refer 10 cost reports that should have been referred to CMS for reconciliation.

Cost Reports Within the 3-Year Reopening Limit

Of the 10 cost reports that Noridian did not refer to CMS for reconciliation, 3 cost reports had not been settled and should have been referred to CMS for reconciliation. Noridian did not refer the three cost reports to CMS because Noridian 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.[15] As a result of the inadequacy of these control procedures:

- Noridian did not perform the reconciliation test to identify and refer two cost reports that qualified for reconciliation and

- Noridian did not refer one other cost report that qualified for reconciliation even though Noridian correctly performed the reconciliation test and recognized that it qualified for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these three unreferred cost reports totaled at least $6,919,974 that was due to Medicare.

Cost Reports Outside the 3-Year Reopening Limit

Of the 10 cost reports that Noridian did not refer to CMS for reconciliation, the remaining 7 cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. Noridian did not refer the seven cost reports to CMS because Noridian 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:

- Noridian did not perform the reconciliation test to identify and refer two cost reports that qualified for reconciliation and

- Noridian did not correctly perform the reconciliation test for five cost reports and incorrectly concluded that those cost reports did not meet the criteria for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these seven cost reports totaled at least $17,667,277 that may be due to Medicare.

[15] Two of these cost reports were also on hold because of the SSI-related litigation discussed in "Background." The other was on hold because of a congressional inquiry.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 11 referred cost reports whose outlier payments qualified for reconciliation, Noridian reconciled the outlier payments associated with 6 cost reports by December 31, 2011. However, Noridian did not reconcile the outlier payments associated with five cost reports by December 31, 2011. The statuses of the cost reports with unreconciled outlier payments were as follows:

- three cost reports were on hold because CMS had not calculated revised SSI ratios and
- two cost reports were on hold because of a congressional inquiry.

For the five cost reports that were referred but whose outlier payments had not been reconciled, CMS or other external entities bore principal responsibility for the delays that we have described above.[16]

For the five referred cost reports whose outlier payments Noridian did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least $7,213,678 that was due to Medicare.

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with the three cost reports that were within the 3-year reopening limit was at least $6,919,974 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 seven 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 $17,667,277 that may be due to Medicare.

Finally, for the five referred cost reports whose outlier payments Noridian did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least $7,213,678 that was due to Medicare.

RECOMMENDATIONS

We recommend that Noridian:

- review the three 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 $6,919,974 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

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

- review the seven 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 $17,667,277 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the five cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the $7,213,678 in associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare;

- 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;

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

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

AUDITEE COMMENTS

In written comments on our draft report, Noridian concurred with all of our recommendations, described corrective actions that it had taken or planned to take, and provided information as to the status of certain cost reports that agreed with our own analysis of their status.

Regarding the cost reports that had exceeded the 3-year reopening limit, Noridian said that it could not reopen those cost reports because of CMS instructions.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Noridian's comments, we maintain that all of our findings and recommendations remain 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." Specifically, 42 CFR § 405.1885(b)(3) provides that a Medicare payment contractor (e.g., Noridian) 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 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. Therefore, we continue to recommend that Noridian determine whether these seven providers procured Medicare funds by "similar fault" and work with CMS to resolve their $17,667,277 in outlier payments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Noridian 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.[17] If the cost reports had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and calculated the amounts due to Medicare or to providers.

We performed fieldwork at Noridian's office in Fargo, North Dakota, and followup audit work in our Denver, Colorado, field office, from November 2010 to April 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 Noridian 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 Noridian officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed Noridian'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 Noridian's jurisdiction as of October 27, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that Noridian had referred to CMS for reconciliation during our audit period;
- obtained the cost report data from CMS's database for cost reports with fiscal-year ends during our audit period;

[17] 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[18] 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 Noridian used the three different types of outlier payments specified by Federal regulations[19] (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;

- requested that Noridian provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;[20]

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

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

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

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

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

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

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

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

- calculated accrued interest[21] 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 Noridian officials on April 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.

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

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

Table 1: Total Cost Reports and Amounts Due

Grand Total	Due to Medicare	Due to Provider
21 Cost Reports	**$42,210,630**	**$1,633,764**

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	3	7	10	10
Balance Due to Medicare	0	0	$5,848,685	$13,761,100	$19,609,785	$19,609,785
Interest Due to Medicare	0	0	1,071,289	3,906,177	4,977,466	4,977,466
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**	**$6,919,974**	**$17,667,277**	**$24,587,251**	**$24,587,251**
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	6	0	5	0	5	11
Balance Due to Medicare	$9,622,015	0	$6,654,672	$0	$6,654,672	$16,276,687
Interest Due to Medicare	787,686	0	559,006	0	559,006	1,346,692
Balance Due to Provider	1,512,529	0	0	0	0	1,512,529
Interest Due to Provider	121,235	0	0	0	0	121,235
Total Due to Medicare	**$10,409,701**	**0**	**$7,213,678**	**0**	**$7,213,678**	**$17,623,379**
Total Due to Provider	**$1,633,764**	**0**	**$0**	**$0**	**$0**	**$1,633,764**

APPENDIX C: AUDITEE COMMENTS

noridian
Healthcare Solutions

900 42nd Street South
Fargo, ND 58103

July 8, 2014

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

Dear Mr. Cogley:

Noridian Healthcare Solutions, LLC (Noridian) has reviewed the draft report, A-07-10-02774, entitled *Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required.* Below are our comments and responses to the OIG's recommendations.

Noridian concurs with all of the recommendations.

OIG Recommendation: Review the three 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 $6,919,974 in funds and associated interest from health care providers, and refund that amount to the Federal Government.

> **Noridian Response:** The three cost reports were referred to CMS for outlier reconciliation approval prior to the notice of program reimbursement dates. Noridian has completed the outlier reconciliation for one of the cost reports. This cost report is on hold because of a congressional inquiry and will be refunded as soon as the inquiry is resolved. Noridian will complete the outlier reconciliations to refund the amounts for the other two cost reports once CMS provides approval.

OIG Recommendation: Review the seven 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 $17,667,277 in funds and associated interest from health care providers that may be due to the Federal Government.

> **Noridian Response:** The seven cost reports were not properly addressed. Noridian cannot reopen these cost reports because the final NPR was issued and the three-year reopening period has lapsed. Based on IOM 100-06, Chapter 8, Section 100, cost reports may not be reopened beyond three years unless there is evidence of fraud or similar fault is involved. This was confirmed with the CMS Central Office. Noridian has not identified evidence of fraud or similar fault for the seven cost reports.

OIG Recommendation: Review the five cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the $7,213,678 in

A CMS Medicare Administrative Contractor

Noridian Healthcare Solutions, LLC

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associated outlier payments due to the Federal Government, finalize these cost reports, and ensure that the providers return the funds to Medicare.

> **Noridian Response:** The three cost reports on hold because CMS had not calculated revised SSI ratios have now had the outlier reconciliations completed and the cost reports have been finalized with the funds returned to Medicare. Noridian has completed the outlier reconciliations to refund the amounts for the other two cost reports. However, they are on hold because of a congressional inquiry and will be finalized and refunded as soon as this is resolved.

OIG Recommendation: 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.

> **Noridian Response:** Noridian has procedures in place that require outlier reconciliations for all applicable cost reports before final settlement. These procedures also address the need to reopen cost reports that have already been settled.

OIG Recommendation: Ensure that policies and procedures are in place so that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines.

> **Noridian Response:** Noridian has procedures in place to reconcile outlier payments for providers approved by CMS.

OIG Recommendation: 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.

> **Noridian Response:** We have reviewed all cost reports submitted since the end of the audit period. The cost reports are reviewed to determine if it meets the criteria for an outlier reconciliation for all providers as part of our regular desk review process. Those that meet the outlier reconciliation criteria are referred and reconciled in accordance with federal guidelines.

We appreciate the opportunity to comment on this report and the findings. If you have any questions on this response and Noridian's actions, please contact me at 701-282-1356.

Sincerely,

Emy Stenerson

Emy Stenerson,
Senior Vice President and JF Project Manager

cc: Pamela Bragg, JF COR, CMS
Tom McGraw, CEO and President of Noridian Healthcare Solutions, LLC