Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TRAILBLAZER HEALTH ENTERPRISES DID NOT ALWAYS REFER MEDICARE COST REPORTS AND RECONCILE OUTLIER PAYMENTS AS REQUIRED

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Office of Inspector General

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EXECUTIVE SUMMARY

TrailBlazer Health Enterprises 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 $2.8 million that should be recouped from health care providers and returned to Medicare. In addition, TrailBlazer 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, TrailBlazer Health Enterprises (TrailBlazer), had been since 2008 the Medicare contractor for Jurisdiction 4, which comprises Colorado, New Mexico, Oklahoma, and Texas. In October 2012, TrailBlazer's responsibilities transitioned to Novitas Solutions, Inc.; accordingly, we are addressing our recommendations to Novitas.

The objectives of this review were to determine whether TrailBlazer (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 TrailBlazer had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.

WHAT WE FOUND

Of 65 cost reports with outlier payments that qualified for reconciliation, TrailBlazer referred 56 cost reports to CMS in accordance with Federal guidelines. However, TrailBlazer did not refer nine cost reports that should have been referred to CMS for reconciliation. Of these, four 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 four cost reports and (2) the recalculated outlier payments totaled at least $2,782,480. We refer to this difference as financial impact. The five 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 five cost reports totaled $6,654,859.

Of the 56 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, TrailBlazer had reconciled the outlier payments associated with 31 cost reports by December 31, 2011. However, TrailBlazer had not reconciled the outlier payments associated with the remaining 25 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 24 of the 25 cost reports that were referred but not reconciled was at least $31,772,948. We also calculated that $661,074 was due from Medicare to a provider for 1 of the 25 cost reports that were referred but not reconciled.

Because certain providers require specialized recalculations for their outlier payments, we were unable to recalculate 942 of the 4,043 claims associated with the cost reports that we were recalculating and are setting aside $6,838,228 in outlier payments associated with those claims for resolution by Novitas and CMS.

WHAT WE RECOMMEND

We recommend that Novitas:

- review the 4 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 $2,782,480 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

- review the 5 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 $6,654,859 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the 25 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:

    - reconcile the $31,772,948 in associated outlier payments due to the Federal Government (24 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and

    - reconcile the $661,074 in associated outlier payments due from Medicare to a provider (1 cost report), finalize that cost report, and return the funds to the provider;

- work with CMS to resolve the $6,838,228 in outlier payments associated with the 942 claims that we could not recalculate;

- 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

Auditee Comments

In written comments on our draft report, Novitas described corrective actions that it had taken or planned to take in response to most of our recommendations. Specifically, Novitas said that it would work to address the proper settlement of the cost reports (both unsettled and settled) that were within the 3-year reopening limit (in our first recommendation). Novitas also said that it has specific procedures in place that address our fifth and sixth recommendations.

In response to our second recommendation—regarding cost reports that were settled and had exceeded the 3-year reopening limit—Novitas said that it could not reopen those cost reports because of CMS instructions. Novitas said that in addition to the 5 unreferred cost reports that we had identified as exceeding the 3-year reopening limit, 6 of the 25 cost reports that were referred to CMS (and that we addressed in our third recommendation) were also beyond the 3-year reopening limit. For our fourth recommendation, Novitas stated that it would work with

CMS to address the $6,838,228 in outlier payments associated with the 942 claims that we could not recalculate once it had received supporting documentation on those claims. In response to our final recommendation, Novitas stated that it would review "applicable" cost reports that TrailBlazer had reviewed from January 1 through October 26, 2012 (when TrailBlazer's Medicare contractor responsibilities transitioned to Novitas), and added that it would refer and reconcile those cost reports that meet the outlier reconciliation criteria in accordance with Federal guidelines and instructions.

Our Response

After reviewing Novitas's comments, we maintain that all of our findings and recommendations remain valid. With respect to our second recommendation, CMS regulations allow for cost reports to be reopened if there is evidence of "similar fault." After sending us its written comments and then communicating with us regarding our third recommendation, Novitas determined that TrailBlazer had initiated action to reopen the six cost reports that were referred to CMS and that Novitas had identified in its written comments as having exceeded the 3-year reopening limit. Accordingly, Novitas will be able to take corrective action to complete the reconciliation process for those six cost reports.

We gave Novitas the requested supporting documentation associated with the 942 claims mentioned in our fourth recommendation.

With respect to our final recommendation, we continue to hold that Novitas should review cost reports submitted since the end of our audit period to ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines before they exceed the 3-year reopening limit.

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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, TrailBlazer Health Enterprises (TrailBlazer), had been since 2008 the Medicare contractor for Jurisdiction 4, which comprises Colorado, New Mexico, Oklahoma, and Texas. In October 2012, TrailBlazer's responsibilities transitioned to Novitas Solutions, Inc.; accordingly, we are addressing our recommendations to Novitas.

OBJECTIVES

Our objectives were to determine whether TrailBlazer (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]

[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.

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 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.

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.

[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.

[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)).

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 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.[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

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[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.

[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).

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.

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 TrailBlazer 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

[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.

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

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

Appendix A contains details of our audit scope and methodology.

FINDINGS

Of 65 cost reports with outlier payments that qualified for reconciliation, TrailBlazer referred 56 cost reports to CMS in accordance with Federal guidelines. However, TrailBlazer did not refer nine cost reports that should have been referred to CMS for reconciliation. Of these, four 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 four cost reports and (2) the recalculated outlier payments totaled at least $2,782,480. We refer to this difference as financial impact.[14] The five 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 five cost reports totaled $6,654,859.

Of the 56 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, TrailBlazer had reconciled the outlier payments associated with 31 cost reports by December 31, 2011. However, TrailBlazer had not reconciled the outlier payments associated with the remaining 25 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 24 of the 25 cost reports that were referred but not reconciled was at least $31,772,948. We also calculated that $661,074 was due from Medicare to a provider for 1 of the 25 cost reports that were referred but not reconciled.

Because certain providers require specialized recalculations for their outlier payments, we were unable to recalculate 942 of the 4,043 claims associated with the cost reports that we were recalculating and are setting aside $6,838,228[15] in outlier payments associated with those claims for resolution by Novitas and CMS.

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

[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.

[15] This amount is separate from the financial impact amounts mentioned in the two immediately preceding paragraphs.

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 65 cost reports with outlier payments that qualified for reconciliation, TrailBlazer referred 56 cost reports to CMS in accordance with Federal guidelines. However, TrailBlazer did not refer nine cost reports that should have been referred to CMS for reconciliation.

Cost Reports Within the 3-Year Reopening Limit

Of the nine cost reports that TrailBlazer did not refer to CMS for reconciliation, four had not been settled and should have been referred to CMS for reconciliation. Because TrailBlazer 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 four cost reports.[16] We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these four unreferred cost reports totaled at least $2,782,480 that was due to Medicare.

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

Cost Reports Outside the 3-Year Reopening Limit

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

- TrailBlazer did not perform the reconciliation test to identify and refer one cost report that qualified for reconciliation,

- TrailBlazer did not correctly perform the reconciliation test for one cost report and incorrectly concluded that that cost report did not meet the criteria for reconciliation, and

- TrailBlazer did not refer three other cost reports that qualified for reconciliation even though TrailBlazer correctly performed the reconciliation test and recognized that they qualified for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these five cost reports totaled at least $6,654,859 that may be due to Medicare.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 56 referred cost reports whose outlier payments qualified for reconciliation, TrailBlazer reconciled the outlier payments associated with 31 cost reports by December 31, 2011. However, TrailBlazer did not reconcile the outlier payments associated with 25 cost reports by December 31, 2011. The statuses of the cost reports with unreconciled outlier payments were as follows:

- 15 cost reports were on hold because CMS had not calculated revised SSI ratios,

- 6 cost reports were on hold because CMS had not calculated revised SSI ratios and because of pending updates to the FISS Lump Sum Utility software that prevented the recalculation of outlier payments, and

- 4 cost reports had been correctly referred but were still being processed before final settlement (1 cost report was awaiting CMS approval to reconcile the outlier payments, 2 had received CMS approval and were undergoing the reconciliation process, and 1 was pending updates to the FISS Lump Sum Utility software).

For the two cost reports that had received CMS approval and were undergoing the reconciliation process, TrailBlazer's policies and procedures did not ensure that it reconciled all outlier payments associated with all referred cost reports that qualified for reconciliation in accordance with Federal guidelines. For the other 23 cost reports that were referred but whose outlier

payments had not been reconciled, CMS bore principal responsibility for the delays that we have described above.[17]

For the 25 referred cost reports whose outlier payments TrailBlazer did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least $31,772,948 that was due to Medicare (24 cost reports) and $661,074 that was due to a provider (1 cost report).

CLAIMS THAT COULD NOT BE RECALCULATED

The 25 referred cost reports with unreconciled outlier payments included 942 claims with $6,838,228 in associated outlier payments. We were unable to recalculate these claims for certain providers (that is, rehabilitation providers) because they required specialized recalculations for their outlier payments. We are therefore setting aside the $6,838,228 for resolution by Novitas and CMS. We are separately providing detailed data on the claims that we could not recalculate to Novitas.

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with the four unreferred cost reports that were within the 3-year reopening limit was at least $2,782,480 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 five 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 $6,654,859 that may be due to Medicare.

Finally, for the 25 referred cost reports whose outlier payments TrailBlazer did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least $31,772,948 that was due to Medicare (24 cost reports) and $661,074 that was due to a provider (1 cost report). Therefore, the net financial impact to Medicare of the 25 cost reports with unreconciled outlier payments was at least $31,111,874.

RECOMMENDATIONS

We recommend that Novitas:

- review the 4 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 $2,782,480 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

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

- review the 5 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 $6,654,859 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the 25 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:

    - reconcile the $31,772,948 in associated outlier payments due to the Federal Government (24 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and

    - reconcile the $661,074 in associated outlier payments due from Medicare to a provider (1 cost report), finalize that cost report, and return the funds to the provider;

- work with CMS to resolve the $6,838,228 in outlier payments associated with the 942 claims that we could not recalculate;

- 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, Novitas described corrective actions that it had taken or planned to take in response to most of our recommendations. Specifically, Novitas said that it would work to address the proper settlement of the cost reports (both unsettled and settled) that were within the 3-year reopening limit (in our first recommendation). Novitas also said that it has specific procedures in place that address our fifth and sixth recommendations.

For the five cost reports that were settled and had exceeded the 3-year reopening limit (in our second recommendation), Novitas said that it could not reopen those cost reports because CMS instructions do not allow for reopening cost reports beyond 3 years unless there is evidence of fraud by the provider or there is a pending Provider Reimbursement Review Board or court ruling. Novitas said that in addition to those 5 cost reports, 6 of the 25 cost reports that were

referred to CMS (and that we addressed in our third recommendation) were also beyond the 3-year reopening limit.

For our fourth recommendation, Novitas stated that it would work with CMS to address the $6,838,228 in outlier payments associated with the 942 claims that we could not recalculate once it had received supporting documentation on those claims.

In response to our final recommendation, Novitas stated that it would review "applicable" cost reports that TrailBlazer had reviewed from January 1 through October 26, 2012 (when TrailBlazer's Medicare contractor responsibilities transitioned to Novitas), and added that it would refer and reconcile those cost reports that meet the outlier reconciliation criteria in accordance with Federal guidelines and instructions.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

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

For our second recommendation, 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., Novatis) 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. Accordingly, we continue to recommend that Novitas determine whether these five providers procured Medicare funds by "similar fault" and work with CMS to resolve their $6,654,859 in outlier payments.

Regarding our third recommendation, we asked Novitas to verify whether TrailBlazer had reopened the six cost reports that were referred to CMS and that Novitas had identified in its written comments as having exceeded the 3-year reopening limit. Novitas determined that TrailBlazer had issued Notices of Intent to reopen those six cost reports before they had exceeded the 3-year reopening limit. Accordingly, Novitas will be able to take corrective action to complete the reconciliation process for those six cost reports.

After receiving Novitas's comments, we gave Novitas the supporting documentation associated with the 942 claims that we could not recalculate and that are the basis of our fourth recommendation.

With respect to our final recommendation, we acknowledge Novitas's statement that it would review and act on the "applicable" cost reports that TrailBlazer had reviewed from January 1 through October 26, 2012 (the date the contractor responsibilities transitioned to Novitas). At

the same time, though, we continue to recommend that Novitas review cost reports submitted since December 31, 2008 (the end of our audit period). Cost reports submitted before January 1, 2012, could have outlier payments that qualify for reconciliation and that could still be within the 3-year reopening limit. Under the terms of the transition in Medicare contractor responsibilities, Novitas has the authority to ensure that those cost reports whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

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 TrailBlazer 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 fieldwork at TrailBlazer's office in Dallas, Texas, and followup audit work in our Denver, Colorado, field office, from December 2010 to April 2013.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to TrailBlazer 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 TrailBlazer officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed TrailBlazer'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 TrailBlazer's jurisdiction as of December 2, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that TrailBlazer 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;

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

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

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

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

    - verified the original outlier payments using the CCR that was used to pay the claim;[22]

[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 TrailBlazer.

[22] We set aside claims whose original outlier payments we could not verify.

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

- identified those claims that we were unable to recalculate either because we could not verify the original outlier payment calculation for particular claims, because the claims were for providers that required specialized recalculations, or because some of the CCRs from the CMS database were so anomalous as to be of questionable reliability; and

- calculated accrued interest[23] 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 Novitas officials on April 2, 2013.

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

[23] 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
65 Cost Reports	**$67,231,817**	**$6,826,625**

Table 2: Cost Reports Not Referred (OIG Identified)

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		Past 3 Years	Not Reconciled Sub-Total	
		In Process	On Hold			
Number of Cost Reports	0	0	4	5	9	9
Balance Due to Medicare	0	0	$2,308,750	$5,206,485	$7,515,235	$7,515,235
Interest Due to Medicare	0	0	473,730	1,448,374	1,922,104	1,922,104
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**	**$2,782,480**	**$6,654,859**	**$9,437,339**	**$9,437,339**
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 Sub-Total	
		In Process	On Hold			
Number of Cost Reports	31	4	21	0	25	56
Balance Due to Medicare	$23,916,035	$2,007,620	$26,517,842	$0	$28,525,462	$52,441,497
Interest Due to Medicare	2,105,494	228,881	3,018,605	0	3,247,486	5,352,980
Balance Due to Provider	5,708,420	611,483	0	0	611,483	6,319,903
Interest Due to Provider	457,131	49,591	0	0	49,591	506,722
Total Due to Medicare	**$26,021,529**	**$2,236,501**	**$29,536,447**	**$0**	**$31,772,948**	**$57,794,477**
Total Due to Provider	**$6,165,551**	**$661,074**	**$0**	**$0**	**$661,074**	**$6,826,625**

Note: The dollar amounts associated with these cost reports do not reflect the 942 claims that we were unable to recalculate.

APPENDIX C: AUDITEE COMMENTS

NOVITAS SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE PART A

January 23, 2014

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

RE: **A-07-10-02776**, Trailblazer Health Enterprises OIG Findings Associated with the review of Medicare Outlier Reconciliations.

Mr. Cogley,

We have reviewed the OIG Report #A-07-10-02776 and noted the specific recommendations included in this report. We offer the following comments in response to each of the report's recommendations.

1. "Review the 4 cost reports that had not been settled and should have been referred to CMS for reconciliation, take appropriate actions to refer these cost reports, request CMS approval to recoup $2,782,480 in funds and associated interest from health care providers, and refund the amount to the Federal Government."

   Response: As the new JH MAC contractor, we will work to address the proper settlement of these four cost report's Outlier reconciliation. In reviewing the listing of the applicable 4 cost reports, we have noted that 2 of the 4 were settled by TBE in October 2012 and one was settled by Novitas in March 2013. We will issue Notice of Intent to Reopen letters for these 3 settled cost reports to ensure that the three-year window to reopen the cost report for the outlier reconciliation is kept open. The fourth cost report is still on hold.

2. "Review the 5 cost reports that have been settled, that exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation, determine whether these cost reports can be reopened, and work with CMS to resolve $6,654,859 in funds, and associated interest from health care providers that may be due to the Federal Government"

   Response: These five cost reports were not properly addressed timely by Trailblazer Health Enterprises (TBE). With the final NPR being issued in addition to the three-year reopening period having lapsed, we cannot "Reopen" these cost reports. CMS instructions do not allow for the reopening of a cost report beyond three years unless there is evidence of fraud by the provider or there is a pending PRRB or Court ruling.

3. "Review the 25 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and with CMS to:

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INNOVATION IN ACTION
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- Reconcile the $31,772,948 in associated outlier payments due to the Federal Government (24 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare.
- Reconcile the $661,074 in associated outlier payments due from the Federal Government (1 cost report), finalize that cost report, and return the funds to the provider."

Response: As we review the 25 cost reports addressed in this report, we note that 5 of these were settled by TBE. We will need to review the supporting documentation, but we believe that TBE did complete the Outlier Reconciliation for these 5. We also note that there are 6 of the 25 cost reports where the cost report was settled more than three years ago; therefore, the cost report cannot be reopened at this point to address the reconciliation. For the remaining 14 cost reports, Novitas will work to complete the reconciliation process in coordination with CMS.

4. "Work with CMS to resolve the $6,838,228 in outlier payments associated with the 942 claims that we could not recalculate."

   Response: Currently, Novitas does not have in its possession any supporting documentation that addresses the 942 claims in question. Novitas will certainly work with CMS to address these outlier payment issues with these claims, once additional supporting documentation is available.

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

   Response: Currently, Novitas does have in place specific procedures that require an Outlier Reconciliation for all applicable cost reports before final settlement. These procedures address the communication of those cost reports in need of an outlier reconciliation to CMS as well as the need to reopen those cost reports that have already been settled.

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

   Response: Currently, Novitas does have in place specific procedures that require an Outlier Reconciliation for all applicable cost reports before final settlement. These procedures address the communication of those needing reconciliation to CMS as well as the need to reopen those cost reports that have already been settled.

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

   Response: Novitas will review applicable cost reports where TBE completed the review of the cost report for the period beginning January 1, 2012 through October 26, 2012 (the date of TBE transition of MAC workload to Novitas Solutions). Those that meet the Outlier reconciliation criteria will be referred and reconciled in accordance with Federal guidelines and CMS instructions.

If you have any questions, please let me know.

Sincerely,

Timothy LeJeune, Director
JH Provider Audit and Reimbursement