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August 2025 | A-06-24-05003

Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements for Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers

REPORT HIGHLIGHTS

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Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements for Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers

Why OIG Did This Audit

- Medicare providers are required to submit annual cost reports to their Medicare administrative contractor (MACs). These financial documents convey the providers' costs associated with providing services to Medicare enrollees. MACs use the reports in determining the final amounts due providers for their cost reporting periods (the final settlements of the cost reports).
- MACs perform a mandatory desk review to determine the accuracy and reasonableness of the data contained in a provider's cost report. The desk review does not include detailed verification and is designed to identify issues that may warrant additional review in the form of an audit by the MAC.
- This audit assessed cost reports that one MAC, Novitas Solutions, Inc. (Novitas), reopened to correct final settlements. We performed this audit to determine whether any of the cost reports that Novitas settled with a desk review only and then reopened to correct the final settlements contained obvious errors or were inconsistent with Medicare requirements.

What OIG Found

Of the 118 cost reports (totaling 122 cost report reopenings because some were reopened more than once) that Novitas settled with a desk review only and that Novitas reopened to correct the final settlements, all of the associated desk reviews contained obvious errors or were inconsistent with Medicare requirements.

- The 122 cost report reopenings resulted in corrected final settlements to providers totaling $9.4 million (which consisted of $5.0 million in overpayments and $4.4 million in underpayments).
- Novitas reported to us that its auditors and supervisors required additional training on certain types of payments. Novitas added that its supervisors did not detect the incorrect audit adjustments.
- The risk exists that delays in the correct settlement of the cost reports could prevent some Medicare funds from being expended in the most efficient and effective ways.

What OIG Recommends

We recommend that Novitas develop and provide additional education to desk reviewers and supervisors on applicable criteria and review requirements; and that Novitas develop and implement enhanced procedures, which expand upon the current procedures and which are not limited to the additional training for which Novitas has already identified a need, so that supervisors are better qualified to detect incorrect audit adjustments.

Novitas concurred with both of our recommendations and described the corrective actions it had taken to address them.

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INTRODUCTION

WHY WE DID THIS AUDIT

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

After performing a desk review of the cost report, the MAC issues a Notice of Program Reimbursement (NPR) to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to Medicare.

One of the Centers for Medicare & Medicaid Services's (CMS's) goals is for MACs to arrive at correct settlements of their cost reports. If there is an error made in the final settlement, the cost report final settlement can be reopened and adjusted to correct for the error.[2]

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

We performed this audit to determine whether Novitas Solutions, Inc. (Novitas), which has 2 MAC jurisdictions (Jurisdictions H and L) covering 11 States and the District of Columbia, reopened and corrected cost report final settlements because of desk review errors.[3]

This audit is part of a series of audits in which we have reviewed the correctness of final settled cost reports and the correctness of final settlements for which the relevant MAC performed a desk review only.[4]

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

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

[3] MAC Jurisdiction H consists of the States of Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas. MAC Jurisdiction L consists of the States of Delaware, Maryland, New Jersey, and Pennsylvania, and the District of Columbia.

[4] See Appendix B for a list of related Office of Inspector General (OIG) reports.

OBJECTIVE

Our objective was to determine whether, for the cost reports that Novitas settled with a desk review only and that Novitas reopened to correct the final settlements, any of the desk reviews contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Novitas**.**

BACKGROUND

Medicare Program

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

Medicare Cost Reports

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

Providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the MAC performs a tentative settlement, then performs a desk review of the cost report and may conduct an audit, as appropriate, before final settlement.[5]

Medicare Administrative Contractor Cost Report Reviews

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

[5] 42 CFR § 413.64(f)(2); *Provider Reimbursement Manual*, CMS Pub. No. 15-1, part 1, § 2408.2; *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.

MACs must conduct desk reviews of cost reports for all providers that file a Medicare cost report. Exceptions are made for cost reports for hospices and for providers that have low or no Medicare utilization. A desk review is an analysis of the provider's cost report to evaluate its adequacy and completeness and determine the accuracy and reasonableness of the data contained in the cost report. This process does not include detailed verification and is designed to identify issues that may warrant additional review. The purpose of the desk review is to determine whether the cost report can be settled without an audit or whether an audit is necessary.[6] In contrast to the desk review, an audit is an examination of financial transactions that tests the provider's compliance with the law, regulations, and Medicare manual instructions.

All work performed by the MAC's staff during the desk review is subject to appropriate supervision, which includes instructing staff members, reviewing the work performed (supervisory review), and providing effective on-the-job training to ensure audit quality.[7]

At the conclusion of the desk review and a subsequent decision not to perform an audit, the MAC issues an NPR to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to the Medicare program.[8]

Cost Report Reopenings

A cost report final settlement may be reopened at the request of the provider or on the MAC's own initiative within 3 years of the date of the NPR to re-examine and adjust the final determination of the amount of total reimbursement due the provider (42 CFR § 405.1885).[9] The MAC's decision to reopen a settled cost report generally depends on whether new and material evidence has been submitted by the provider, an error was made during the final settlement process, or the settled cost report is found to be inconsistent with the law, regulations, and manual instructions (*Provider Reimbursement Manual*, part I, § 2931.2).

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

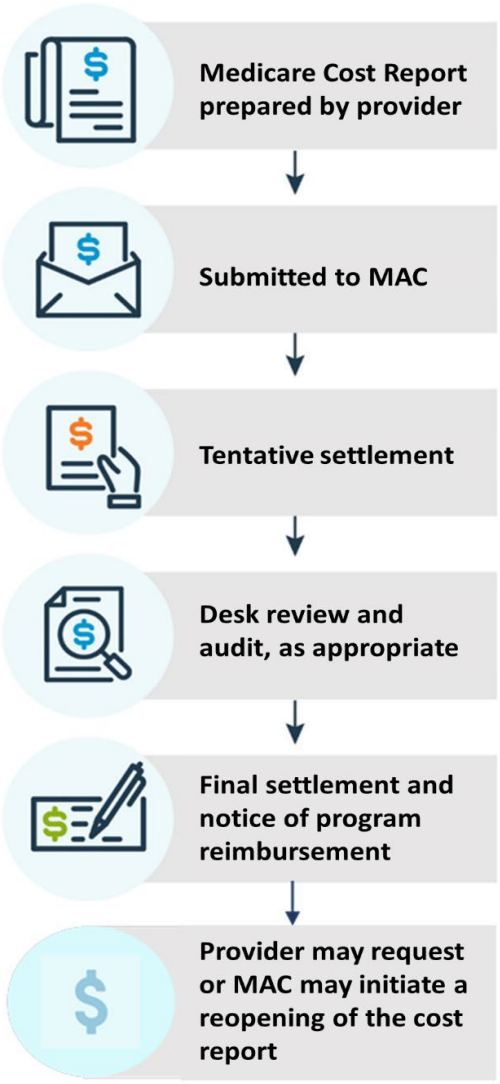
[6] *Medicare Financial Management Manual,* CMS Pub. No. 100-06, chapter 8, § 20.1.

[7] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 20.3 and 60.13.

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

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

Figure: Medicare Cost Report Process



HOW WE CONDUCTED THIS AUDIT

For both Novitas MAC jurisdictions, we obtained information regarding 118 final settled cost reports for fiscal years (FYs) ending in 2016 and 2017 and for which Novitas performed a desk review only,[10] and which had been reopened because of one or more errors on Novitas's part. Novitas reopened some of these 118 desk-reviewed cost reports more than once, for a total of 122 cost report reopenings. For these 122 cost report reopenings, we obtained workpapers, adjustments, and final settlement summaries to identify: whether the provider requested the

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

reopening or Novitas initiated the reopening, the reasons for the reopening, and the effect of the corrected final settlement.

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

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

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

FINDING

NOVITAS SOLUTIONS, INC., REOPENED A TOTAL OF 118 COST REPORTS BECAUSE OF OBVIOUS ERRORS IT MADE

We determined that of the 118 cost reports (totaling 122 cost report reopenings) that Novitas settled with a desk review only and that Novitas reopened to correct the final settlements, all of the associated desk reviews contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Novitas. These errors involved omitting, misclassifying, misreporting, miscalculating, or duplicating adjustments.

Novitas officials reported that auditors and supervisors required additional training applicable to certain payments and bad debts. These officials added that Novitas supervisors who performed reviews did not detect the incorrect adjustments. The number and types of errors we identified in the cost reports we reviewed point to the need for such additional training to be augmented by enhanced procedures for cost report reviews.

The 122 cost report reopenings resulted in corrected final settlements to providers totaling $9,364,954 (which consisted of $4,963,475 in overpayments and $4,401,479 in underpayments). Moreover, although an analysis of time delays was not part of our methodology for this audit, the risk exists that delays in the correct settlement of cost reports could prevent some Medicare funds from being expended in the most efficient and effective ways.

The table on the following page shows the cost report reopening impacts for 11 categories of errors that we identified. It is followed by examples of the obvious errors for some of the 122 cost report reopenings. Appendix C provides details about the laws, regulations, and Medicare

manual instructions that Novitas cited in its adjustments for 11 categories of errors that we identified.

Table: Cost Report Reopening Impacts for 11 Categories of Errors

Error Category Number	Error Category	Number of Errors	(Overpayment) Amount (OP)	Underpayment Amount (UP)	Net Amount—OP + UP	Total of Payment Errors—OP + UP
1	Settlement Data	60	($4,077,326)	$2,076,111	($2,001,215)	$6,153,437
2	HITECH[11]	15	(44,062)	302,111	258,049	346,173
3	Other*	13	(70,205)	1,001, 796	931,591	1,072,001
4	Graduate Medical Education (GME) Per-Resident Amount	10	(229,410)	141,280	(88,130)	370,690
5	Bad Debts	8	(18,482)	30,124	11,642	48,606
6	Provider Statistical & Reimbursement Report (PS&R)	5	(90,629)	34,803	(55,826)	125,432
7	Disproportionate Share Hospital Payments	5	(231,644)	327,810	96,166	559,454
8	QASP[12]	2	0	176,905	176,905	176,905
9	Hospital-Acquired Conditions (HAC)	2	0	310,539	310,539	310,539
10	Worksheet S-10 (W/S S-10)	1	0	0	0	0
11	GME/Indirect Medical Education (IME) Full-Time Equivalents (FTEs)	1	(201,717)	0	(201,717)	201,717
Totals		**122**	**($4,963,475)**	**$4,401,479**	**($561,996)**	**$9,364,954**

*Error category number 3, Other, represents various obvious errors in the final settlement that we did not separately categorize.

Details on the laws, regulations, and Medicare manual instructions cited by Novitas in its adjustments for these 11 categories of errors appear in Appendix C.

[11] The Health Information Technology for Economic and Clinical Health Act (HITECH), established by the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Feb. 17, 2009), incentivized the meaningful use of electronic health records.

[12] The purpose of the CMS Quality Assurance Surveillance Plan (QASP) is to measure the Medicare administrative contractors' compliance with their Statement of Work requirements.

EXAMPLES FOR EACH CATEGORY OF ERRORS ACCORDING TO NOVITAS SOLUTIONS, INC.

Error Category Number 1—Settlement Data (Omitted)

According to Novitas, it initiated a reopening of the final settlement because it omitted a biweekly payment and tentative adjustment from the cost report. The reopening adjustment of the final settlement resulted in a $596,963 overpayment to the provider. Novitas cited 42 CFR §§ 412.110 and 413.20 and CMS Pub. No. 15-1, § 2408.4, as the Medicare requirements for the reopening adjustment.

Error Category Number 2—Health Information Technology for Economic and Clinical Health Act (Misreported)

According to Novitas, it initiated a reopening of the final settlement because an incorrect HITECH transition factor was used for the HITECH settlement. The reopening adjustment of the final settlement resulted in a $123,074 underpayment to the provider. Novitas cited 42 CFR §§ 495.100 and 495.104(c) as the Medicare requirements on the reopening adjustment report.

Error Category Number 3—Other (Omitted)

According to Novitas, it initiated the reopening of the final settlement amount because related organization costs from the home office were not reflected as costs on the cost report. Novitas added that it issued a notice of reopening to incorporate the related organization costs. The reopening adjustment of the final settlement resulted in a $560,557 underpayment to the provider. Novitas cited 42 CFR § 413.17 and CMS Pub. No. 15-1, § 2150, as the Medicare requirements for the reopening adjustment.

Error Category Number 4—Graduate Medical Education Per-Resident Amount (Misreported)

According to Novitas, it initiated a reopening of the final settlement because it used an incorrect per-resident amount (PRA) for GME payments during the desk review.[13] Specifically, a schedule that Novitas used to update the PRA was updated incorrectly. The reopening adjustment of the final settlement resulted in a $109,357 overpayment to the provider. Novitas cited 42 CFR § 413.77 as the Medicare requirement on the reopening adjustment report.

[13] The PRA for GME payments is generally calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in that base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA by the weighted number of full-time equivalent residents working in all areas of the hospital (and non-hospital sites, when applicable), and by the hospital's Medicare share of total inpatient days.

Error Category Number 5—Bad Debts (Duplicated)

According to Novitas, it initiated a reopening of the final settlement because, based on its review of a successive FY, it discovered that the provider had duplicated its bad debt claim for some patients in the current and prior cost reporting periods. The reopening adjustment of the final settlement resulted in a $3,401 overpayment to the provider. Novitas cited 42 CFR § 413.89 and CMS Pub. No. 15-1, §§ 316 and 2304, as the Medicare requirements on the reopening adjustment report.

Error Category Number 6—Provider Statistical and Reimbursement Report (Duplicated)

According to Novitas, it initiated the reopening of the final settlement amount because it duplicated deductible, coinsurance, and interim payment amounts from the PS&R. The reopening adjustment of the final settlement resulted in a $34,803 underpayment to the provider. Novitas cited 42 CFR §§ 413.64 and 412.1102.116 and CMS Pub. No. 15-1, §§ 2405 and 2406, as the Medicare requirements for the reopening adjustment.

Error Category Number 7—Disproportionate Share Hospital Payments (Misreported)

According to Novitas, it initiated a reopening of the final settlement because it used an incorrect Supplemental Security Income (SSI) percentage for DSH payments on the cost report. Novitas added that it also misreported a deductible amount on the final settlement. The reopening adjustment of the final settlement resulted in a $229,660 overpayment to the provider. Novitas cited 42 CFR § 412.106 for the DSH payments and 42 CFR § 412.110 and CMS Pub. No. 15-1, § 2408.4, for the deductible amount as the Medicare requirements for the reopening adjustment.

Error Category Number 8—CMS Quality Assurance Surveillance Plan (Misreported)

According to Novitas, it initiated a reopening of the final settlement based on a review by CMS's Quality Assurance branch. This review identified that the Nursing and Allied Health Education worksheet B-1 statistics were applied incorrectly. The reopening adjustment of the final settlement resulted in a $33,975 underpayment to the provider. Novitas cited 42 CFR §§ 413.85 and 413.87 as the Medicare requirements for the reopening.

Error Category Number 9—Hospital-Acquired Conditions (Misreported)

According to Novitas, it initiated a reopening of the final settlement because it used the incorrect HAC table year on a cost report when it should have used the table for a different year. This resulted in a reopening to reflect the fact that there was no HAC reduction for the cost report in question. The reopening adjustment of the final settlement resulted in a $269,123 underpayment to the provider. Novitas cited 42 CFR §§ 412.110 and 413.20 and CMS Pub. No. 15-1, § 2408.4, as the Medicare requirements for the reopening adjustment.

Error Category Number 10—Worksheet S-10 (Misreported)

According to Novitas, it initiated a reopening of the final settlement because, based on its review, Novitas did not use the latest amended cost report during the desk review. (Novitas used the first amended cost report instead of the second amended cost report.) In addition, Novitas adjusted worksheet S-10 incorrectly. The reopening adjustment of the final settlement resulted in a $0 underpayment or overpayment to the provider. Novitas cited the Affordable Care Act § 3133 and CMS Pub. No. 15-2, § 4012, as the Medicare requirements on the reopening adjustment report.

Error Category Number 11—Graduate Medical Education/Indirect Medical Education Full-Time Equivalents (Misreported and Omitted)

According to Novitas, it initiated a reopening of the final settlement amount because it incorrectly entered the prior year FTEs that did not reflect a full year for GME payments. Novitas added that it also did not enter the prior year intern-to-bed ratio for IME payments. The reopening adjustment of the final settlement resulted in a $201,717 overpayment to the provider. Novitas cited 42 CFR § 413.79 and CMS Pub. No. 15-2, § 4034, for the prior year FTEs, and 42 CFR § 412.105 and CMS Pub. No. 15-2, § 4030.1, for the prior year intern-to-bed ratio, as the Medicare requirements for the reopening adjustment.

RECOMMENDATIONS

We recommend that Novitas Solutions, Inc.:

- develop and provide additional education to desk reviewers and supervisors regarding applicable criteria and review requirements and

- develop and implement enhanced procedures, which expand upon the current procedures and which are not limited to the additional training for which Novitas has already identified a need, so that supervisors are better qualified to detect incorrect adjustments.

NOVITAS SOLUTIONS, INC., COMMENTS

In written comments on our draft report, Novitas concurred with both of our recommendations and described the corrective actions it had taken to address them. These actions include continuing to examine its supervisory review procedures “to avoid and eliminate obvious errors;” continuing to develop and deliver continuing education to auditors based on the needs and requirements identified by Novitas’s training team, audit staff, and CMS; and continuing to “review and enhance its quality procedures to ensure [that] staff are properly assigned reviews based on their level of expertise.”

Specifically, for our first recommendation Novitas stated that corrective actions were taken to address similar findings for reopenings based on results from its internal quality control (IQC) reviews. These corrective actions consisted of "educating team members, improving processes, testing new processes, and implementing new processes." Novitas also described additional aspects of its quality review and internal training processes.

For our second recommendation, Novitas said that it examines its processes and procedures "on an annual basis" as well as after its IQC reviews or CMS QASP (footnote 12) reviews that identify findings. In addition, Novitas stated that it "ensures that staff meet specific job requirements before they can progress to a higher level" and described a procedure that, for consistency, establishes the expectations of auditors performing supervisory reviews. Novitas also described its use of a quality checklist and the process by which it verifies the adjustments against the electronic files before issuing a final settlement.

Novitas's comments appear in their entirety as Appendix D

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For both Novitas MAC jurisdictions, we obtained information regarding 118 final settled cost reports for FYs ending in 2016 and 2017 and for which Novitas performed a desk review only (footnote 10), and which had been reopened because of one or more errors on Novitas's part. Novitas reopened some of these 118 desk-reviewed cost reports more than once, for a total of 122 cost report reopenings that we reviewed. For Novitas's two MAC jurisdictions (Jurisdictions H and L; footnote 3), we obtained for further review information for 2016 and 2017 cost reports that had been reopened because of Novitas errors.

For these 122 cost report reopenings, we obtained workpapers, adjustments, and final settlement summaries to identify: whether the provider requested the reopening or Novitas initiated the reopening, the reasons for the reopening, and the effect of the corrected final settlement.

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

We assessed internal controls necessary to satisfy the audit objective. In particular, we gained an understanding of, and reviewed, Novitas's policies and procedures regarding supervisory review before the final settlement of cost reports. On the basis of these audit steps, we assessed Novitas's ability to detect errors in the cost reports for which it had performed a desk review only.

We performed audit work from March 2024 through June 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and Medicare manual instructions;
- obtained and reviewed information from Novitas related to cost reports for which Novitas performed a desk review only, as well as subsequent cost report reopenings, for FYs 2016 and 2017;
- obtained and reviewed, for the 122 cost report reopenings, the reopening documentation, including the reasons for the reopening, the root causes of the errors that Novitas identified, and the impacts of the reopened final settlements;

- obtained and reviewed Novitas's policies and procedures for its desk reviews, its reopening process, and its process for supervisory review;

- assessed the adequacy of Novitas's supervisory review to detect errors in cost reports for which Novitas performed a desk review only; and

- discussed the results of our audit with Novitas officials.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
National Government Services, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers	A-06-24-05000	10/28/2024
Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers	A-06-23-05001	9/11/2024
Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers	A-06-22-05000	11/1/2023

APPENDIX C: LAWS, REGULATIONS, AND MEDICARE MANUAL INSTRUCTIONS CITED BY NOVITAS SOLUTIONS, INC., IN ITS ADJUSTMENTS FOR THE 11 CATEGORIES OF ERRORS IN OUR EXAMPLES

ERROR CATEGORY NUMBER 1—SETTLEMENT DATA

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare enrollee by a hospital will equal the sum of the payments listed in 42 CFR §§ 412.112 through 412.115, reduced by the amounts specified in § 412.120 (42 CFR § 412.110).

Hospitals are paid a prospective payment rate on a per-case basis for: operating costs for each discharge, capital-related costs, outlier payment amounts, and additional payments for new medical services and technologies, as appropriate (42 CFR § 412.112). The hospital receives other payments, such as direct medical education costs, organ acquisition costs, and various other costs (42 CFR § 412.113). The hospital is paid for additional expenses, such as those associated with bad debts, administration of blood clotting factors, and other expenses (42 CFR § 412.115). The hospital's payments may be reduced by applicable deductible and coinsurance amounts, and by other payers that are primary to Medicare (42 CFR § 412.120).

The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital field are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially, the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to enrollees (42 CFR § 413.20).

After reviewing a cost report and any audit findings pertaining to it, the MAC determines the total allowable cost for the period of provider operations covered by the cost report and the total reasonable cost reimbursement due the provider for the services furnished during this period. Provider agreement with these determinations, although preferred, is not required (CMS Pub. No. 15-1, § 2408.4).

When these determinations have been made, the MAC makes a final retroactive adjustment, if one is required. In making a final adjustment, the MAC reduces the payment by any monies owed the program by the provider; e.g., a past-due accelerated payment or an unrecovered overpayment (CMS Pub. No. 15-1, § 2408.4).

ERROR CATEGORY NUMBER 2—HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT

Section 1886(n) of the Act, amended by section 4102(a) of the HITECH (P.L. No. 111-5; footnote 11), describes the methodology for determining the incentive payment amount for eligible hospitals that are meaningful users of certified EHR technology during the EHR reporting period for a payment year. Incentive payments for each payment year are calculated as the product of: (1) an initial amount, (2) the Medicare share, and (3) a transition factor applicable to that payment year (42 CFR § 495.104(c)).

A qualifying hospital under this statute is a Medicare-eligible hospital that is a meaningful electronic health record (EHR) user for the EHR reporting period applicable to a payment or payment adjustment year (42 CFR § 495.100).

ERROR CATEGORY NUMBER 3—OTHER

With certain exceptions, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere (42 CFR § 413.17). Two types of related organizations are chain organizations and home offices.

A chain organization consists of a group of two or more health care facilities that are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations that are engaged in other activities not directly related to health care (CMS Pub. No. 15-1, § 2150).

Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent that the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs (CMS Pub. No. 15-1, § 2150).

ERROR CATEGORY NUMBER 4—GRADUATE MEDICAL EDUCATION PER-RESIDENT AMOUNT

GME payments attributable to additional FTE residents are calculated using the updated PRA (footnote 13). The updated PRA is adjusted by the projected changes in the Consumer Price Index for all urban consumers that occurred during the cost reporting period (42 CFR § 413.77).

ERROR CATEGORY NUMBER 5—BAD DEBTS

Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations described in this section and the exception for services described in this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Medicare program (42 CFR § 413.89). Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case in which the amount was uncollectible (CMS Pub. No. 15-1, § 316).

Where the provider was reimbursed by Medicare for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period (CMS Pub. No. 15-1, § 316).

Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to enrollees. This includes all ledgers, books, records, and original evidences of cost (such as purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor timecards, payrolls, and bases for apportioning costs), which pertain to the determination of reasonable cost and are capable of being audited (CMS Pub. No. 15-1, § 2304).

ERROR CATEGORY NUMBER 6—PROVIDER STATISTICAL AND REIMBURSEMENT REPORT

Providers of services paid on the basis of the reasonable cost of services furnished to enrollees will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule that is administratively feasible, but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period (42 CFR § 413.64).

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare enrollee by a hospital will equal the sum of the payments listed in 42 CFR §§ 412.112 through 412.115, reduced by the amounts specified in § 412.120 (42 CFR § 412.110).

Hospital payments may be reduced by applicable deductible and coinsurance amounts, and payments by other payers that are primary to Medicare (42 CFR § 412.120).

Payment for items reimbursable on a reasonable cost basis will be made on an interim basis, subject to retrospective adjustment based on a submitted cost report (CMS Pub. No. 15-1, § 2405.2).

The interim rate for covered outpatient services and those medical and other health services furnished to inpatients under Part B must be expressed as a percentage of charges (CMS Pub. No. 15-1, § 2406).

ERROR CATEGORY NUMBER 7—DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Section 1886(d)(5)(F) of the Act, implemented by 42 CFR § 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients.

Hospitals' disproportionate share calculation is determined by the number of patient days for patients entitled to Medicare Part A and SSI for the period divided by the number of discharge days for Medicare Part A patients, including those enrolled in Medicare Advantage (42 CFR § 412.106(b)(2)).

Subject to a reduction factor, if a hospital services a disproportionate share of low-income patients, its diagnosis-related group (DRG) revenues for inpatient operating costs are increased by an adjustment factor (42 CFR § 412.106(d)).[14]

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare enrollee by a hospital will equal the sum of the payments listed in 42 CFR §§ 412.112 through 412.115, reduced by the amounts specified in § 412.120 (42 CFR § 412.110).

Hospitals' payments may be reduced by applicable deductible and coinsurance amounts and payments by other payers that are primary to Medicare (42 CFR § 412.120).

After reviewing a cost report and any audit findings pertaining to it, the MAC determines the total allowable cost for the period of provider operations covered by the cost report and the total reasonable cost reimbursement due the provider for the services furnished during this period. Provider agreement with these determinations, although preferred, is not required. When these determinations have been made, the MAC makes a final retroactive adjustment, if one is required. In making a final adjustment, the MAC reduces the payment by any monies owed the program by the provider; e.g., a past-due accelerated payment or an unrecovered overpayment (CMS Pub. No. 15-1, § 2408.4).

[14] Under the Medicare inpatient prospective payment system, Medicare pays hospitals predetermined rates for patient discharges. The rates vary according to the DRG to which an enrollee's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the enrollee's stay.

ERROR CATEGORY NUMBER 8—CMS QUALITY ASSURANCE SURVEILLANCE PLAN

Hospitals may receive additional Medicare reimbursement for the cost of operating an approved nursing and allied health education program based on the methodology for determining the additional payments (42 CFR § 413.87).

ERROR CATEGORY NUMBER 9—HOSPITAL-ACQUIRED CONDITIONS

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare enrollee by a hospital will equal the sum of the payments listed in 42 CFR §§ 412.112 through 412.115, reduced by the amounts specified in § 412.120 (42 CFR § 412.110).

Hospitals are paid a prospective payment rate on a per-case basis for operating costs for each discharge, capital-related costs, outlier payment amounts, and additional payments for new medical services and technologies, as appropriate (42 CFR § 412.112).

Hospitals are paid other payments, such as direct medical education costs, organ acquisition costs, and other costs (42 CFR § 412.113).

Hospitals are paid for additional expenses, such as those associated with bad debts, administration of blood clotting factors, and other expenses (42 CFR § 412.115).

Hospitals' payments may be reduced by applicable deductible and coinsurance amounts and payments by other payers that are primary to Medicare (42 CFR § 412.120).

Providers must maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare program (42 CFR § 413.20).

After reviewing a cost report and any audit findings pertaining to it, the MAC determines the total allowable cost for the period of provider operations covered by the cost report and the total reasonable cost reimbursement due the provider for the services furnished during this period. When these determinations have been made, the MAC makes a final retroactive adjustment, if one is required. In making a final adjustment, the MAC reduces the payment by any monies owed the program by the provider (Pub. No. 15-1, § 2408.4).

ERROR CATEGORY NUMBER 10—WORKSHEET S-10

Section 3133 of the Patient Protection and Affordable Care Act of 2010 (ACA) states that for each of FYs 2015, 2016, and 2017, hospitals shall be paid an additional amount based on several arithmetic factors, including a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals: (1) who are uninsured in 2012, the last year before coverage expansion under the ACA (as calculated based on the most recent estimates available from the

Congressional Budget Office before Congress voted on the ACA); and (2) who are uninsured in the most recent period for which data is available (as so calculated).[15]

Section 112(b) of the Balanced Budget Refinement Act of 1999 requires that short-term acute care hospitals (§ 1886(d) of the Act) submit in their cost reports data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated.[16] Worksheet S-10 provides for the collection of the required data (CMS Pub. No. 15-2, § 4012).

ERROR CATEGORY NUMBER 11—GRADUATE MEDICAL EDUCATION/INDIRECT MEDICAL EDUCATION FULL-TIME EQUIVALENTS

For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, the hospital's weighted FTE resident count is equal to the average of the weighted FTE resident count for the payment year cost reporting period and the preceding two cost reporting periods (42 CFR § 413.79(d)(2)). The regulations and manual instructions regarding the calculation and reporting of GME FTEs can be found at 42 CFR § 413.79 and CMS Pub. No. 15-2, § 4034. The regulations and manual instructions regarding the calculation and reporting of the IME intern-to-bed ratio can be found at 42 CFR § 412.105 and CMS Pub. No. 15-2, § 4030.1.

[15] The Patient Protection and Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010).

[16] The Medicare, Medicaid, and SCHIP [Separate Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, P.L. No. 106-113 (Nov. 29, 1999).

APPENDIX D: NOVITAS SOLUTIONS, INC., COMMENTS

NOVITAS SOLUTIONS

June 30, 2025

OFFICE OF AUDIT SERVICES, REGION VI 1100 COMMERCE
STREET, ROOM 632
DALLAS, TX 75242

RE: A-06-23-05003

Novitas appreciates the opportunity to address the concerns presented by the Office of Inspector General in the report labeled *Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements for Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers.* It is noteworthy to mention that Novitas was responsible for accurately reporting more than 10,000 NPR cost reports that were processed under Jurisdiction H and L (JH and JL) in their previous business periods.

As noted in OIG's report, Novitas identified and self-disclosed the errors that are mentioned. The reopenings were performed per the regulations to correct the errors identify by Novitas. It is also noteworthy to mention that eleven of the 122 reopenings make up approximately $6 million of the $9 million noted in this report. Thus, it is our opinion that the dollar impact on these errors is not an indication that these issues exist on a wider scale. We acknowledge the assessment performed by OIG and believe that we should continue to examine our supervisory review procedures to avoid and eliminate obvious errors.

The following are recommendations from OIG and Novitas' responses:
OIG Recommendation 1:
Develop and provide additional education to desk reviewers and supervisors on applicable criteria and review requirements.
MAC Response to Recommendation 1:
Novitas is in concurrence that we must continue to develop and deliver continuing education to auditors based on the needs and requirements identified by our training team, Audit staff, and CMS. As previously mentioned in the report, the issues cited were identified, self-disclosed, any money due to or from the program has been properly collected or paid by Novitas and have been part of past trainings and/or corrective actions. Moreover, these issues have been commonly addressed in CMS' QASP trainings and/or Novitas' internal trainings. Additionally, corrective actions were taken to address similar findings for reopenings based on results from our internal quality control (IQC) reviews. The corrective actions consisted of educating team members, improving processes, testing new processes, and implementing new processes. Each month our IQC team performs quality reviews on desk reviews, audits, and reopenings as part of our Quality Measurement Report (QMR) supplied to CMS. It is noteworthy to mention that we recently expanded the number of units selected for quality review to ensure a greater consistency in the quality of work. In addition, each month our IQC team provides high findings report from quality reviews to ensure audit team members are aware of issues, such as those identified in the OIG report, and they should be on the lookout for or know how to address as part desk reviews, audits, and reopenings being performed.

OIG Recommendation 2: *Develop and implement enhanced procedures, which expand upon the current procedures and which are not limited to the additional training for which Novitas has already identified a need, so that supervisors are better qualified to detect incorrect audit adjustments.*
MAC Response to Recommendation 2:

2020 Technology Parkway Suite 100 Mechanicsburg, PA 17050 www.novitassolutionsinc.com

Novitas is in concurrence with continuing to review and enhance its quality procedures to ensure staff are properly assigned reviews based on their level of expertise. Although Novitas has quality processes in place that should help avoid any obvious errors, we believe that there is a need to continuously examine our processes and procedures, and they are examined on an annual basis, as well as after IQC or QASP reviews where there are findings. It is noteworthy to mention that Novitas ensures that staff meet specific job requirements before they can progress to a higher level and begin performing supervisory review of work in order to detect incorrect audit adjustments. For consistency, our Perform Supervisory Review of Desk Review Procedure establishes the expectations of auditors performing supervisory reviews. Also, as part of our desk review and final settlement process, Novitas uses a quality checklist to ensure the minimum quality expectations have been performed, which includes a verification of all adjustments.
Additionally, since this report was issued, Novitas has also implemented a process to perform verification of the adjustments against the electronic files, used to generate the final cost report, prior to issuing a final settlement. In conclusion, Novitas acknowledges the issues and recommendations mentioned in the report by OIG and will continue to look for ways to improve the work we do. We are thankful for OIG's willingness to work with us, share their recommendations, provide us an opportunity to offer our responses to this matter, and allow us to take any action needed to better our processes. We will continue to examine our review processes and procedures to be the best version of ourselves.

Sincerely,

Deborah A Taylor Digitally signed by Deborah A Taylor
Date: 2025.06.30 15:04:42 -04'00'

Deborah Taylor Vice President & COO Novitas Solutions, Inc.

Report Fraud, Waste, and Abuse

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

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

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

How Does It Help?

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

Who Is Protected?

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

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Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov