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

August 2025 | A-06-24-05004

# National Government Services, 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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# National Government Services, 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 (MAC). 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, National Government Services, Inc. (NGS), reopened to correct final settlements. We performed this audit to determine whether any of the cost reports that NGS 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 60 cost reports (totaling 64 cost report reopenings because some were reopened more than once) that NGS settled with a desk review only and that NGS reopened to correct final settlements, all of the associated desk reviews contained obvious errors or were inconsistent with Medicare requirements.

- The 64 cost report reopenings resulted in corrected final settlements to providers totaling $5.6 million (which consisted of $3.1 million in overpayments and $2.5 million in underpayments).
- NGS reported to us that its auditors and supervisors required additional training on certain types of payments. NGS 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 NGS develop and provide additional education to desk reviewers and supervisors on applicable criteria and review requirements; and that NGS develop and implement enhanced procedures, which expand upon the current procedures, and which are not limited to the additional training for which NGS has already identified a need, so that supervisors are better qualified to detect incorrect audit adjustments.

NGS 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' (CMS's) goals is for MACs to arrive at correct settlements of the cost report. 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 National Government Services, Inc. (NGS), which has multiple MAC jurisdictions (Jurisdictions 6 and K) covering 10 States, 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 audits and the correctness of final settlements for which the relevant MAC performed a desk review only.[4]

[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 6 consists of the States of Illinois, Minnesota, and Wisconsin. MAC Jurisdiction K consists of the States of Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont.

[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 NGS settled with a desk review only and that NGS 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 NGS**.**

## BACKGROUND

### Medicare Program

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

### Medicare Cost Reports

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

Providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the MAC performs a tentative settlement, then performs a desk review of the cost report and 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 decision by the MAC 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.

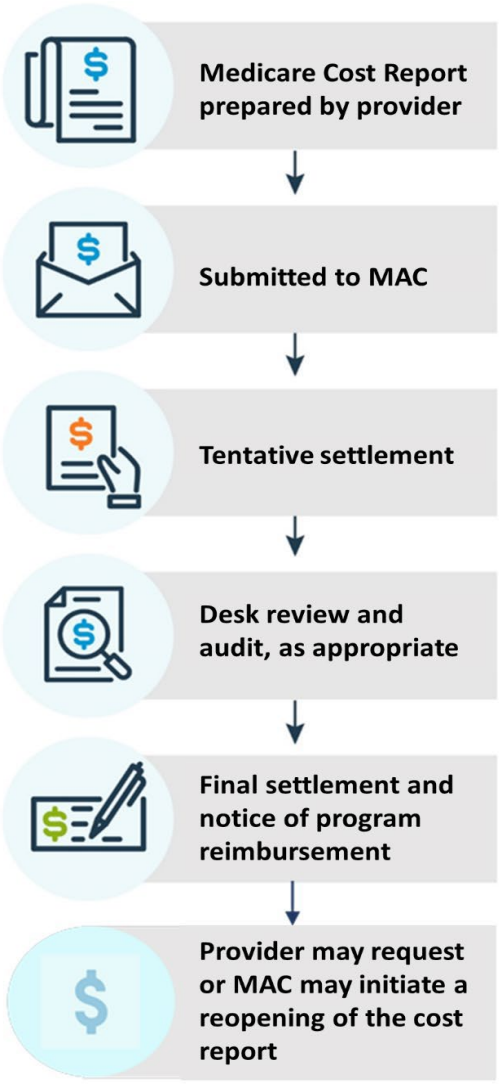
[6] *Medicare Financial Management Manual,* CMS Pub. No. 100-06, chapter 8, § 20.1**.**

[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 the NGS MAC jurisdictions, we obtained information regarding 60 final settled cost reports for fiscal years (FYs) ending in 2016 and 2017 and for which NGS performed a desk review only,[10] and which had been reopened because of one or more errors on NGS's part. NGS reopened some of these 60 desk-reviewed cost reports more than once, for a total of 64 cost report reopenings. For these 64 cost report reopenings, we obtained workpapers, adjustments, and final settlement summaries to identify: whether the provider requested a reopening or NGS

[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.

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

NGS 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

### NATIONAL GOVERNMENT SERVICES, INC., REOPENED A TOTAL OF 60 COST REPORTS BECAUSE OF OBVIOUS ERRORS IT MADE

We determined that of the 60 cost reports (totaling 64 cost report reopenings) that NGS settled with a desk review only and that NGS 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 NGS. These errors involved omitting, misclassifying, misreporting, miscalculating, or duplicating adjustments.

NGS officials reported that auditors and supervisors required additional training applicable to certain payments and bad debts. These officials added that NGS 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 64 cost report reopenings resulted in corrected final settlements to providers totaling $5,641,691 (which consisted of $3,132,111 in overpayments and $2,509,580 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 15 categories of errors that we identified. It is followed by examples of the obvious errors for some of the 64 cost report reopenings. Appendix B provides details about the laws, regulations, and Medicare manual instructions that NGS cited in its adjustment for 15 categories of errors that we identified.

**Table: Impact for 15 Error Categories**

| 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 | Graduate Medical Education (GME) Per-Resident Amount | 12 | ($77,113) | $216,139 | $139,026 | $293,252 |
| 2 | Other* | 9 | (1,107,714) | 733,253 | (374,461) | 1,840,967 |
| 3 | Settlement Data | 9 | (2,600) | 28,152 | 25,552 | 30,752 |
| 4 | Disproportionate Share Hospital Payments | 6 | (113,013) | 31,368 | (81,645) | 144,381 |
| 5 | Provider Statistical & Reimbursement Report (PS&R) | 5 | (58,748) | 7,804 | (50,944) | 66,552 |
| 6 | GME/Indirect Medical Education (IME)—Full-Time Equivalents (FTEs) | 4 | (167,831) | 809,078 | 641,247 | 976,909 |
| 7 | GME/IME—Other | 4 | (311,800) | 0 | (311,800) | 311,800 |
| 8 | Adjustments Not Entered | 3 | (1,183,989) | 3,564 | (1,180,425) | 1,187,553 |
| 9 | Health Information Technology for Economic and Clinical Health Act (HITECH) | 3 | 0 | 41,629 | 41,629 | 41,629 |
| 10 | Statistics | 3 | (64,532) | 9,398 | (55,134) | 73,930 |
| 11 | Low-Volume Payment | 2 | 0 | 370,711 | 370,711 | 370,711 |
| 12 | Cost Issues | 1 | (13,306) | 0 | (13,306) | 13,306 |
| 13 | Geographical Reclassification | 1 | (31,465) | 0 | (31,465) | 31,465 |
| 14 | GME/IME/Hospital-Acquired Conditions | 1 | 0 | 26,564 | 26,564 | 26,564 |
| 15 | Hospital-Specific Payment | 1 | 0 | 231,920 | 231,920 | 231,920 |
| **Total** | | 64 | **($3,132,111)** | **$2,509,580** | **($622,531)** | **$5,641,691** |

*Error category number 2, 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 NGS in its adjustments for these 15 categories of errors appear in Appendix C.

## EXAMPLES OF EACH CATEGORY OF ERRORS ACCORDING TO NATIONAL GOVERNMENT SERVICES, INC.

### Error Category Number 1—Graduate Medical Education Per-Resident Amount (Misreported)

According to NGS, it initiated a reopening of the final settlement because it used an incorrect per-resident amount (PRA) for GME payments during the desk review.[11] The reopening adjustment of the final settlement resulted in a $109,409 underpayment to the provider. NGS cited 42 CFR § 413.77 as the Medicare requirement on the reopening adjustment report.

### Error Category Number 2—Other (Misreported)

According to NGS, it initiated a reopening of the final settlement amount because it used an incorrect outpatient outlier payment amount during the reconciliation. The reopening adjustment of the final settlement resulted in an $842,161 overpayment to the provider. NGS cited CMS Pub. No. 15-2, § 4030.2, as the Medicare requirement for the reopening adjustment.

### Error Category Number 3—Settlement Data (Misreported)

According to NGS, it initiated a reopening of the final settlement because it used an incorrect lump-sum payment that had been previously recorded on the cost report. The reopening adjustment of the final settlement resulted in a $10,555 underpayment to the provider. NGS did not cite a regulation or CMS manual (guidance) for the reopening adjustment.

### Error Category Number 4—Disproportionate Share Hospital Payments (Misreported)

According to NGS, it initiated a reopening of the final settlement because it used an incorrect Supplemental Security Income (SSI) percentage for disproportionate share payments on the cost report. NGS added that it also misreported a deductible amount on the final settlement. The reopening adjustment of the final settlement resulted in a $46,081 overpayment to the provider. NGS cited 42 CFR § 412.106(b)(2) and (d) and CMS Pub. No. 15-2, §§ 3630.1 and 4030.1, as the Medicare requirements for the reopening adjustment.

[11] 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—Provider Statistical and Reimbursement Report (Misreported)**

According to NGS, it initiated a reopening of the final settlement amount because it used an incorrectly structured PS&R to record payments. At the start of the cost reporting period, the provider was classified as an urban provider, but subsequently it was geographically reclassified and ended the cost reporting period as a rural provider. NGS acknowledged that the PS&R should have been split during the cost reporting period to reflect the reclassification and to record the correct payment amounts. The reopening adjustment of the final settlement resulted in a $53,572 overpayment to the provider. NGS 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 6—Graduate Medical Education/Indirect Medical Education—Full-Time Equivalents (Misreported)**

According to NGS, it initiated a reopening of the final settlement amount because it incorrectly entered only the displaced GME/IME FTEs for the rehabilitation facility. NGS should have also entered rehabilitation facility FTEs for new programs. The reopening adjustment of the final settlement resulted in an $809,078 underpayment to the provider. NGS cited CMS Pub. No. 15-2, §§ 4033.3 and 4005.1, as the Medicare requirements for the reopening adjustment.

**Error Category Number 7—Graduate Medical Education/Indirect Medical Education—Other (Miscalculated)**

According to NGS, it initiated a reopening of the final settlement because the CMS quality assurance surveillance plan's (QASP's) review found that the prior year intern-to-bed ratio had been calculated incorrectly for GME/IME payments.[12] The reopening adjustment of the final settlement resulted in an $82,449 overpayment to the provider. NGS cited 42 CFR § 413.79(f) and CMS Pub. No. 15-2, § 4030.1, as the Medicare requirements for the reopening adjustment.

**Error Category Number 8—Adjustments Not Entered (Omitted)**

According to NGS, it initiated a reopening of the final settlement because two adjustments in the workpapers were not included in the final settlement. The reopening adjustment of the final settlement resulted in a $1,183,989 overpayment to the provider. NGS cited the Benefits Improvement and Protection Act (BIPA) of 2000 (P.L. No. 106-554), the Balanced Budget and Refinement Act (BBRA) of 1999 (P.L. No. 106-113), 42 CFR § 413.87, and 66 Fed. Reg. 3358 (January 12, 2001), for the missing adjustment for the Nursing and Allied Health Medicare managed care payment adjustment. NGS cited 42 CFR § 413.76(d); CMS Pub. No. 15-2, §§ 4004.1 and 4034; CMS Transmittal 10315 (Change Request 12596); and CMS Change Request 11642 for the missing adjustment for the reduction of direct GME Medicare Advantage (MA) payments. NGS cited these Medicare requirements on the reopening adjustment report.

[12] The purpose of the QASP is to measure the Medicare administrative contractors' compliance with their Statement of Work requirements.

**Error Category Number 9—Health Information Technology for Economic and Clinical Health Act (Misreported)**

According to NGS, it initiated a reopening of the final settlement because the permanent file did not contain timely information and, therefore, the depreciation offset for HITECH on Worksheet A-8 was incorrect. The reopening adjustment of the final settlement resulted in a $41,629 underpayment to the provider. NGS cited 42 CFR § 413.134 and CMS Pub. No. 15-2, § 4004.1, as the Medicare requirements on the reopening adjustment report.

**Error Category Number 10—Statistics (Misreported)**

According to NGS, it initiated a reopening of the final settlement because an incorrect statistics code for the Medical Records and Library cost center was used. NGS restored the original gross revenue statistic amounts on Worksheet B-1. The reopening adjustment of the final settlement resulted in a $60,365 overpayment to the provider. NGS cited 42 CFR § 413.24 and CMS Pub. No. 15-2, § 4020, as the Medicare requirements on the reopening adjustment report.

**Error Category Number 11—Low-Volume Payment (Miscalculated)**

According to NGS, it initiated a reopening of the final settlement because of an improper calculation of the low-volume payment. The reopening adjustment of the final settlement resulted in a $232,385 underpayment to the provider. NGS cited 42 CFR § 412.92 and CMS Pub. No. 15-2, § 4030.1, as the Medicare requirements for the reopening adjustment.

**Error Category Number 12—Cost Issues (Misreported)**

According to NGS, the provider requested a reopening of the final settlement because it incorrectly matched expenses and revenues in the Therapies cost centers on the cost report. The reopening adjustment of the final settlement resulted in a $13,306 overpayment to the provider. NGS cited 42 CFR § 413.24 and CMS Pub. No. 15-1, § 2304, as the Medicare requirements for the reopening adjustment.

**Error Category Number 13—Geographical Reclassification (Misreported)**

According to NGS, it initiated a reopening of the final settlement amount because it used an incorrect effective date for the hospital's reclassified geographical status as rural instead of urban. The reopening adjustment of the final settlement resulted in a $31,465 overpayment to the provider. NGS cited CMS Pub. No. 15-2, § 4004.1, as the Medicare requirement for the reopening adjustment.

**Error Category Number 14—Graduate Medical Education/Indirect Medical Education/Hospital-Acquired Conditions (Misreported)**

According to NGS, it initiated a reopening of the final settlement because the CMS QASP's review (footnote 12) found that the prior and penultimate years' FTEs were incorrectly reflected on the cost report for GME/IME payments. Also, the Hospital-Acquired Conditions (HAC) amount was incorrectly computed on the cost report. The reopening adjustment of the final settlement resulted in a $26,564 underpayment to the provider. NGS cited 42 CFR § 413.79 and CMS Pub. No. 15-2, § 4034, for the FTEs and 42 CFR § 412.110 and CMS Pub. No. 15-2, § 4030.1, for the HAC reduction amount, as the Medicare requirements for the reopening adjustment.

**Error Category Number 15—Hospital-Specific Payment (Misreported)**

According to NGS, it initiated a reopening of the final settlement amount because it used an incorrect hospital-specific payment as a consequence of alterations to a standard cost reporting form. The reopening adjustment of the final settlement resulted in a $231,920 underpayment to the provider. NGS cited 42 CFR § 412.108 and CMS Pub. No. 15-2, § 4030.1, as the Medicare requirements for the reopening adjustment.

## RECOMMENDATIONS

We recommend that National Government Services, 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 NGS has already identified a need, so that supervisors are better qualified to detect incorrect adjustments.

## NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In written comments on our draft report, NGS concurred with both of our recommendations and described the corrective actions it had taken to address them. These actions include recalibrating procedures and processes, instituting a checklist to be performed on all desk reviews, and implementing an additional review step prior to final settlement of the cost report. NGS stated that it agreed with our "direction to develop and deliver additional education and enhance procedures to reduce and or eliminate the errors that result in incorrect payments."

Specifically, for our first recommendation NGS described enhancements to its processes, to include monthly technical meetings that address any Internal Quality Control (IQC) findings or

findings from external audits (e.g., CMS's QASP reviews (footnote 12)) and that educate staff on updates to the cost report and to NGS's policies and procedures. Additionally, NGS stated that new staff receive enhanced onboarding efforts and are subsequently assigned a mentor "to answer questions and guide the new auditor as they begin to work on their assignments."

For our second recommendation, NGS stated that it has instituted a checklist to be performed on all desk reviews and audits at the first two levels of its review process and added that it has also implemented an additional review by the Lead Auditor prior to final settlement of the cost report.

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

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

For both NGS MAC jurisdictions, we obtained information regarding 60 final settled cost reports for FYs ending in 2016 and 2017 and for which NGS performed a desk review only (footnote 10), and which had been reopened because of one or more errors on NGS's part. NGS reopened some of these 60 desk-reviewed cost reports more than once, for a total of 64 cost report reopenings that we reviewed. For NGS's two MAC jurisdictions (Jurisdictions 6 and K; footnote 3), we obtained for further review information for 2016 and 2017 cost reports that had been reopened because of NGS errors.

For these 64 cost report reopenings, we obtained workpapers, adjustments, and final settlement summaries to identify: whether the provider requested the reopening or NGS initiated the reopening, the reasons for the reopening, and the effect of the corrected final settlement.

NGS 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, NGS's policies and procedures regarding supervisory review before the final settlement of cost reports. On the basis of these audit steps, we assessed NGS's ability to detect errors in the desk reviewed-only cost reports.

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 NGS related to cost reports for which NGS performed a desk review only, as well as subsequent cost report reopenings, for FYs 2016 and 2017;
- obtained and reviewed, for the 64 cost report reopenings, the reopening documentation, including the reasons for the reopening, the root causes of the errors that NGS identified, and the impacts of the reopened final settlements;
- obtained and reviewed NGS's policies and procedures for its desk reviews, its reopening process, and its supervisory review;

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

- discussed the results of our audit with NGS officials.

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

## APPENDIX B: 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 NATIONAL GOVERNMENT SERVICES, INC., IN ITS ADJUSTMENTS FOR THE 15 CATEGORIES OF ERRORS IN OUR EXAMPLES

### ERROR CATEGORY NUMBER 1—GRADUATE MEDICAL EDUCATION PER-RESIDENT AMOUNT

GME payments attributable to additional FTE residents are calculated using the updated PRA (footnote 11). 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; CMS Pub. No. 15-2, § 4034).

### ERROR CATEGORY NUMBER 2—OTHER

Hospitals may receive outpatient prospective payment system high-cost outlier payments after a reconciliation adjustment. The reconciliation adjustment is made to account for differences between the overall ancillary cost-to-charge ratio (CCR) used to pay the claim at its original submission by the provider and the CCR determined at final settlement of the cost reporting period during which the service was furnished (CMS Pub. No. 100-04, chapter 4, §§ 10.7.2.2 through 10.7.2.4)

Worksheet E, Part B, is used to calculate reimbursement settlement for hospitals and others. Enter on line 91 the outlier reconciliation adjustment in accordance with CMS Pub. 100-04, chapter 4, §§ 10.7.2.2 through 10.7.2.4 (CMS Pub. No. 15-2, § 4030.2).

### ERROR CATEGORY NUMBER 3—SETTLEMENT DATA

NGS did not include any Medicare requirements (regulations or guidance) on the adjustment report for the cost report reopening.

### ERROR CATEGORY NUMBER 4—DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

A hospital's 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 MA (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)).[13] Section 1886(d)(5)(F) of the Social Security Act

[13] Under the Medicare inpatient prospective payment system (IPPS), 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.

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

Enter on line 4 of Worksheet E, Part A, for CMS Form 2552-96, the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from the intermediary/ MAC) (CMS Pub. No. 15-2, § 3630.1).

Enter on line 30 of Worksheet E, Part A, for CMS Form 2552-10, the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from the contractor) (CMS Pub. No. 15-2, § 4030.1).

**ERROR CATEGORY NUMBER 5—PROVIDER STATISTICAL AND REIMBURSEMENT REPORT**

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). The hospital is 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 is paid other payments, such as direct medical education costs, organ acquisition costs, and others (42 CFR § 412.113). The hospital is paid for additional items, such as bad debts, administration of blood clotting factors, and others (42 CFR § 412.115).

The hospital's payments may be reduced by applicable deductible and coinsurance amounts, and payments by workmen's compensation, automobile, medical, and 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 CMS reviews 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, a final retroactive adjustment, if required, is made by the MAC. In making a final adjustment, the MAC reduces the payment by any monies owed the program by the provider (CMS Pub. No. 15-1, § 2408.4).

**ERROR CATEGORY NUMBER 6—GRADUATE MEDICAL EDUCATION/INDIRECT MEDICAL EDUCATION—FULL-TIME EQUIVALENTS**

Worksheet E-3, Part III, is used to report for Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) reimbursement, the number of unweighted intern and resident FTEs in a new approved program for GME (CMS Pub. 15-2, § 4033.3).

Worksheet E-3, Part III, is used to report, for IRF PPS reimbursement, the number of intern and resident FTEs in an approved program for IME (CMS Pub. No. 15-2, § 4005.1).

**ERROR CATEGORY NUMBER 7—GRADUATE MEDICAL EDUCATION/INDIRECT MEDICAL EDUCATION—OTHER**

Worksheet E, Part A, is used to report IME payments. Enter on line 20 the prior year cost report intern- and resident-to-bed ratio by dividing line 12 by line 4 (CMS Pub. No. 15-2, § 4030.1).

**ERROR CATEGORY NUMBER 8—ADJUSTMENTS NOT ENTERED**

An additional hospital GME payment is made for Medicare managed care enrollees in Nursing and Allied Health professional education. The Secretary of Health and Human Services estimates the payment for each year (BBRA of 1999 (P.L. No. 106-113) and BIPA of 2000 (P.L. No. 106-554)). A CMS final rule sets forth in regulations Medicare policy for the payment of costs of approved Nursing and Allied Health education programs (66 Fed. Reg. 3358 (January 12, 2001)). The regulations for additional Nursing and Allied Health payments can be found at 42 CFR § 413.87.

The regulations and manual instructions regarding the calculation and reporting of GME MA payments can be found at 42 CFR § 413.76(d) and CMS Pub. No. 15-2, §§ 4004.1 and 4034.

Change Request 11642 (CMS Transmittal 10315, originally issued August 21, 2020, as updated most recently by Transmittal 10520, issued December 14, 2020) provided instructions to MACs for computing CY 2002 through 2018 Nursing and Allied Health education Medicare Advantage payments to qualifying hospitals, along with the applicable CY percent reduction to be made to a teaching hospital's direct GME MA payment. This Change Request contains a revised Attachment A showing only a revision to the CY 2018 direct GME MA percent reduction (CMS Transmittal 10315 (Change Request 12596)).

**ERROR CATEGORY NUMBER 9—HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT**

Providers may receive reimbursement for providing meaningful use of electronic health record (EHR) technology. An appropriate allowance for depreciation on buildings and equipment used in the provision of care is an allowable cost (42 CFR § 413.134). Enter the reasonable acquisition cost incurred for EHR assets either purchased or initially rented under a virtual purchase lease (CMS Pub. No. 15-2, § 4004.1).

**ERROR CATEGORY NUMBER 10—STATISTICS**

Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on an approved method of cost finding (42 CFR § 413.24). Worksheet A-6 provides for the reclassification of certain costs to effect proper cost allocation under cost finding (CMS Pub.

No. 15-2, § 4014). Worksheet B, Part 1, reports general service costs based on approved cost finding methods (CMS Pub. No. 15-2, § 4020).

**ERROR CATEGORY NUMBER 11—LOW-VOLUME PAYMENT**

For cases in which a sole community hospital experiences a significant volume decrease for any cost reporting period as compared to its immediately preceding period—i.e., a decrease of more than 5 percent in its inpatient total discharges—the MAC provides additional payments (42 CFR § 412.92).

A low-volume payment for an eligible hospital is based on the hospital's total per-discharge payments under section 1886 of the Act. The payment is based on either the Federal rate or the hospital-specific payment rate, whichever results in a greater operating inpatient prospective payment system (IPPS) payment (CMS Pub. No. 15-2, § 4030.1).

**ERROR CATEGORY NUMBER 12—COST ISSUES**

Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on an approved method of cost finding (42 CFR § 413.24). Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to enrollees (CMS Pub. No. 15-1, § 2304).

**ERROR CATEGORY NUMBER 13—GEOGRAPHICAL RECLASSIFICATION**

Worksheet S-2, Part 1, reports the standard geographical classification. The provider's geographical status at the beginning and end of the cost reporting period is entered on lines 26 and 27 (CMS Pub. No. 15-2, § 4004.1).

**ERROR CATEGORY NUMBER 14—GRADUATE MEDICAL EDUCATION/INDIRECT MEDICAL EDUCATION/HOSPITAL-ACQUIRED CONDITIONS**

The regulations and manual instructions for the calculation and reporting of GME FTEs can be found at 42 CFR § 413.79 and CMS Pub. No. 15-2, § 4034.

Section 3008 of the Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148 (Mar. 23, 2010), established the HAC Reduction Program, beginning in FY 2015 (discharges occurring on or after October 1, 2014), for IPPS hospitals to improve patient safety. HACs refer to medical errors or serious infections that patients contract while in the hospital. Under the HAC Reduction Program, a 1 percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specific fiscal year.

Enter on line 70.99 of E, Part A, Exhibit 5, the HAC program payment reduction adjustment amount (CMS Pub. No. 15-2, § 4030.1).

**ERROR CATEGORY NUMBER 15—HOSPITAL-SPECIFIC PAYMENT**

A Medicare IPPS hospital is eligible for Medicare dependent hospital (MDH) classification if it meets certain criteria. MDH operating payments are based on the higher of the Federal rate payment or the Federal rate payment plus 75 percent of the difference between the hospital's Federal rate payment and its hospital-specific rate payment (42 CFR § 412.108).

Worksheet E, Part A, reports on lines 1 through 3, column 1, the applicable payment data to the sole community hospital or Medicare dependent hospital status (CMS Pub. No. 15-2, § 4030.1).

June 26, 2025

Report Number: A-06-24-05004

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

Dear Ms. Wheeler,

As requested, National Government Services (NGS) provides its written comments in response to the draft recommendations the Office of Inspector General made to NGS in draft report *National Government Services, Inc., Reopened and Corrected Cost Report Final Settlements For Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers*, A-06-24-05004. NGS concurs with the OIGs findings for cost reports reopened to make corrections. This included 60 cost reports (64 reopenings in total because some were reopened more than once) out of a total population of 5,163 cost reports final settled with a desk review only.

NGS concurs with the recommendations made by the OIG as follows:

- Draft Recommendation: Develop and provide additional education to desk reviewers and supervisors regarding applicable criteria and review requirements.

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

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

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

  NGS Comment: Concur. NGS has instituted a checklist to be performed on all desk reviews and audits at the Level 1 and Level 2 review process. This ensures that certain steps such as the proper recording of audit adjustments from the workpapers to the adjustment report

to the final cost report are accurately being reported. NGS has also implemented a Level 3 review which is an additional review by the Lead Auditor prior to final settlement of the cost report.

Although the number of reopening errors make up 1% of the desk reviews completed by NGS during the cost reports fiscal years ending 2016 and 2017, we agree with the OIG's direction to develop and deliver additional education and enhance procedures to reduce and or eliminate the errors that result in incorrect payments.

Sincerely,

Jared Griep

Digitally signed by Jared Griep
Date: 2025.06.26 12:18:57 -05'00'

Jared Griep
Jurisdiction 6 Program Manager

Thomas C. Hansen
Jurisdiction K Program Manager

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