

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PALMETTO GOVERNMENT
BENEFITS ADMINISTRATOR
DID NOT ALWAYS REFER
MEDICARE COST REPORTS
AND RECONCILE OUTLIER
PAYMENTS IN JURISDICTION 11**

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EXECUTIVE SUMMARY

Palmetto Government Benefits Administrator did not always refer cost reports whose outlier payments qualified for reconciliation to the Centers for Medicare & Medicaid Services. The financial impact of these unrefereed cost reports was at least \$18.8 million that should be recouped from health care providers and returned to Medicare. In addition, Palmetto did not always reconcile the outlier payments associated with cost reports whose outlier payments qualified for reconciliation.

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) implemented inpatient outlier regulations in 2003 that authorized Medicare contractors to reconcile outlier payments before the settlement of certain hospital cost reports to ensure that these payments reflected the actual costs that each hospital had incurred. CMS policy stated that if a hospital's cost report met specified criteria for reconciliation, the Medicare contractor should refer it to CMS for reconciliation of outlier payments. Effective April 2011, CMS gave Medicare contractors the responsibility to perform reconciliations upon receipt of authorization from the CMS Central Office.

This review is one of a series of reviews to determine whether Medicare contractors had (1) referred the cost reports that qualified for reconciliation and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. One such contractor, Palmetto Government Benefits Administrator, LLC (Palmetto), has been since 2011 the Medicare contractor for Jurisdiction 11, which comprises North Carolina, South Carolina, Virginia, and West Virginia.

The objectives of this review were to determine whether Palmetto (1) referred cost reports to CMS for reconciliation in accordance with Federal guidelines and (2) reconciled the outlier payments associated with the referred cost reports by December 31, 2011.

BACKGROUND

CMS administers Medicare and uses a prospective payment system to pay Medicare-participating hospitals (hospitals) for providing inpatient hospital services to Medicare beneficiaries. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.

Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses due to unusually high-cost cases. Medicare contractors calculate outlier payments on the basis of claim submissions made by hospitals and by using hospital-specific cost-to-charge ratios. Medicare contractors review cost reports that hospitals have submitted, make any necessary adjustments, and determine whether payment is owed to Medicare or to the hospital. In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years after the date of the final settlement of that cost report. We refer to this as the 3-year reopening limit.

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Palmetto had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.

WHAT WE FOUND

Of 23 cost reports with outlier payments that qualified for reconciliation, Palmetto referred 15 cost reports to CMS in accordance with Federal guidelines. However, Palmetto did not refer eight cost reports that should have been referred to CMS for reconciliation. Of these, six cost reports had not been settled or had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with these six cost reports and (2) the recalculated outlier payments totaled at least \$18,883,025. We refer to this difference as financial impact. The two remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation; the financial impact of the outlier payments associated with those two cost reports totaled \$1,641,927.

Of the 15 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Palmetto had reconciled the outlier payments associated with 1 cost report by December 31, 2011. However, Palmetto had not reconciled the outlier payments associated with the remaining 14 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 13 of the 14 cost reports that were referred but not reconciled was at least \$29,033,914. We also calculated that \$386,996 was due from Medicare to a provider for 1 of the 14 cost reports that were referred but not reconciled. The net financial impact of the outlier payments associated with these 14 cost reports that were referred but not reconciled was therefore at least \$28,646,918 that was due to Medicare.

Because certain providers require specialized recalculations for their outlier payments, we were unable to recalculate 146 of the 1,988 claims associated with the cost reports that we were recalculating and are setting aside \$1,114,473 in outlier payments associated with those claims for resolution by Palmetto and CMS.

WHAT WE RECOMMEND

We recommend that Palmetto:

- review the 6 cost reports that had not been settled or had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup \$18,883,025 in funds and associated interest from health care providers, and refund that amount to the Federal Government;
- review the 2 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not; determine whether

these cost reports may be reopened; and work with CMS to resolve \$1,641,927 in funds and associated interest from health care providers that may be due to the Federal Government;

- review the 14 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
 - reconcile the \$29,033,914 in associated outlier payments due to the Federal Government (13 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and
 - reconcile the \$386,996 in associated outlier payments due from Medicare to a provider (1 cost report), finalize that cost report, and return the funds to the provider;
- work with CMS to resolve the \$1,114,473 in outlier payments associated with the 146 claims that we could not recalculate;
- strengthen control procedures to ensure that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;
- strengthen policies and procedures to ensure that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, Palmetto disagreed with our findings and did not concur with our recommendations. On the basis of Palmetto’s comments and its additional documentation, we revised a portion of our discussion of one finding. Otherwise, we maintain that all of our findings, and the associated recommendations, remain valid.

Cost Reports Not Referred

Auditee Comments

With respect to our finding that Palmetto did not refer six cost reports that were within the 3-year reopening limit and that should have been referred to CMS for reconciliation, Palmetto stated that CMS policy does not specify a timeframe within which a cost report that requires reconciliation has to be referred to CMS. Palmetto also stated that CMS instructions mandate that it first complete a “desk review” and conduct any necessary audit activity of a submitted cost

report in order to identify any required adjustments before it, Palmetto, can perform the reconciliation test. Palmetto added that the timing of the desk review and audit activity depends on its audit budget, work plan, and CMS instructions regarding the issuance of certain final cost report settlement documents to hospitals.

With respect to our finding regarding two unrefereed cost reports that had exceeded the 3-year reopening limit, Palmetto stated that the cost-reporting period for one cost report was not under its jurisdiction and said that the other cost report had exceeded the 3-year reopening limit by the time responsibility for this cost report had transferred to Palmetto. Palmetto said that, except in cases of fraud, cost reports cannot be reopened beyond 3 years after the date of their final settlement.

Our Response

We maintain that our findings and the associated recommendations regarding all eight of the unrefereed cost reports remain valid. Palmetto's written comments confirmed that the six unrefereed cost reports that were within the 3-year reopening limit and that qualified for reconciliation had not been referred to CMS as of December 28, 2010 (the start of our audit), as we state in this report.

Although CMS policy does not specify a timeframe within which a cost report that requires reconciliation has to be referred to CMS, CMS instructed Medicare contractors to submit to CMS, between April 1 and April 25, 2011, a list of hospitals whose cost reports had been flagged for reconciliation before April 1, 2011. Moreover, CMS has established timeframes within which Medicare contractors bring cost reports to final settlement. We are not aware of any exceptions, in any CMS guidelines, that permit a Medicare contractor to delay activities, such as desk reviews and cost report settlements, because of its audit budget or work plan. Finally, Medicare contractors should identify cost reports that qualify for outlier reconciliation and refer them to CMS as soon as possible to avoid the unnecessary accrual of additional costs (i.e., interest) due to Medicare or to providers.

With respect to the first of the two unrefereed cost reports that had exceeded the 3-year reopening limit, we disagree with Palmetto's statement that the cost-reporting period for that provider was not under Palmetto's jurisdiction. The statute under which Medicare contractors operate specifies the responsibilities that these contractors acquire because of changes in jurisdictions, providers, or both. Under these provisions, Palmetto (the Medicare contractor since 2011 for Jurisdiction 11) now services this provider and is therefore responsible for adjudicating our recommendations associated with that cost report, even though Palmetto did not have jurisdiction over this particular provider before the transition in responsibilities.

With respect to the second of the two unrefereed cost reports that had exceeded the 3-year reopening limit, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "fraud or similar fault."

Cost Reports Referred but Outlier Payments Not Reconciled

Auditee Comments

With respect to our finding that Palmetto did not reconcile the outlier payments associated with 14 cost reports whose outlier payments qualified for reconciliation, Palmetto said that it had not reconciled all of the cost reports as of December 31, 2011, because CMS had granted extensions. Palmetto also disagreed with our position that a cost report must have been brought to final settlement for the reconciliation process to be considered complete.

Our Response

Our report gives a status update and does not opine as to whether the cost reports were reconciled in accordance with any CMS-established deadlines or extensions.

With respect to Palmetto's disagreement with our position that a cost report must have been brought to final settlement for the reconciliation process to be considered complete, we considered the reconciliation process for a particular cost report to have been completed if all claims had been correctly re-priced and the cost report itself had been brought to final settlement. This approach conforms to CMS guidance.

Procedural Recommendations

Auditee Comments

Palmetto did not concur with our last three recommendations and said that its comments on our findings gave evidence that it already had adequate control procedures in place for cost report referrals and reconciliation of outlier payments.

Our Response

Our findings and our responses to Palmetto's comments provide the evidence for our conclusion that Palmetto's control procedures regarding cost report referral and its policies and procedures for reconciliation of outlier payments were not always adequate.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) implemented inpatient outlier regulations in 2003 that authorized Medicare contractors to reconcile outlier payments before the settlement of certain hospital cost reports to ensure that these payments reflected the actual costs that each hospital had incurred. CMS policy stated that if a hospital's cost report met specified criteria for reconciliation, the Medicare contractor should refer it to CMS for reconciliation of outlier payments.¹ Effective April 2011, CMS gave Medicare contractors the responsibility to perform reconciliations upon receipt of authorization from the CMS Central Office.

In a previous Office of Inspector General (OIG) audit, we reported to CMS that 292 cost reports referred by 9 Medicare contractors for reconciliation had not been settled.² In that audit, we reviewed outlier cost report data submitted to CMS by 9 selected Medicare contractors that served a total of 15 jurisdictions during our audit period (October 1, 2003, through December 31, 2008). To follow up on that audit, we performed a series of reviews (Appendix A) to determine whether the Medicare contractors had (1) referred the cost reports that qualified for reconciliation (a responsibility that already rested with the contractors) and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. One such contractor, Palmetto Government Benefits Administrator (Palmetto), has been since 2011 the Medicare contractor for Jurisdiction 11, which comprises North Carolina, South Carolina, Virginia, and West Virginia.

OBJECTIVES

Our objectives were to determine whether Palmetto (1) referred cost reports to CMS for reconciliation in accordance with Federal guidelines and (2) reconciled the outlier payments associated with the referred cost reports by December 31, 2011.³

¹ Although CMS did not instruct Medicare contractors to refer hospitals in need of reconciliation until 2005, the instructions applied to cost-reporting periods beginning on or after October 1, 2003. Moreover, CMS's instructions during this period changed the responsibility for performing reconciliations. CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003) instructed Medicare contractors to perform reconciliations. Later, Transmittal 707 (Change Request 3966; October 12, 2005) specified that CMS would perform reconciliations.

² *The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance (A-07-10-02764)*, issued June 28, 2012.

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

BACKGROUND

Medicare and Outlier Payments

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

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

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

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

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

To qualify for outlier payments, a claim must have costs that exceed a CMS-established cost threshold. Costs are calculated by multiplying covered charges by a hospital-specific CCR. Because a hospital's actual CCR for any given cost-reporting period cannot be known until final settlement of the cost report for that year, the Medicare contractors calculate and make outlier payments using the most current information available when processing a claim. For discharges occurring on or after October 1, 2003, the CCR applied when a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost-reporting period (42 CFR § 412.84(i)(2)). More than one CCR can be used in a cost-reporting period.

A hospital must submit its cost reports, which can include outlier payments, to Medicare contractors within 5 months after the hospital's fiscal year ends. CMS instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report (*Provider*

Reimbursement Manual, part 2 (PRM-2), § 140). After accepting a cost report,⁴ the Medicare contractor completes its preliminary review and may issue a tentative settlement to the hospital. In general, Medicare contractors perform tentative settlements to make partial payments to hospitals owed Medicare funds (although in some cases a tentative settlement may result in a payment from a hospital to Medicare). This practice helps ensure that hospitals are not penalized because of possible delays in the final settlement process.

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

The Medicare contractor reviews the cost report and may audit it before final settlement. If a cost report is audited, the Medicare contractor incorporates any necessary adjustments to identify reimbursable amounts and finalize Medicare reimbursements due from or to the hospital.⁵ At the end of this process, the Medicare contractor issues the final settlement document, the Notice of Program Reimbursement (NPR), to the hospital. The NPR shows whether payment is owed to Medicare or to the hospital. The final settlement thus incorporates any audit adjustments the Medicare contractor may have made.

In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years⁶ after the date of the final settlement of that cost report (42 CFR § 405.1885(b)). We refer to this as the 3-year reopening limit.

Outlier payments may under certain circumstances be reconciled so that submitted claims can be correctly re-priced before final settlement of a cost report. For this review, we considered the outlier payments associated with a cost report to have been reconciled and the reconciliation process to have been complete if all claims had been correctly re-priced and the cost report itself had been brought to final settlement.

⁴ Medicare contractors do not accept every cost report on its initial submission. Medicare contractors can return cost reports to hospitals for correction, additional information, or other reasons.

⁵ Among other reasons, cost reports may be adjusted to reflect actual expenses incurred or to make allowances for recovery of expenses through sales or fees.

⁶ Cost reports may be reopened by Medicare contractors beyond 3 years for fraud or similar fault (42 CFR § 405.1885(b)(3); *Provider Reimbursement Manual*, part 1 (PRM-1), § 2931.1 (F)).

CMS Changes in the Hospital Outlier Payment Reconciliation Methodology

Outlier Payment Reconciliation

CMS developed new outlier regulations⁷ and guidance in 2003 after reporting that, from Federal fiscal years 1998 through 2002, it paid approximately \$9 billion more in Medicare inpatient PPS (IPPS) outlier payments than it had projected.^{8,9} The 2003 regulations intended to ensure that outlier payments were limited to extraordinarily high-cost cases and that final outlier payments reflected an accurate assessment of the actual costs the hospital had incurred. Medicare contractors were to refer hospitals' cost reports to CMS for reconciliation so CMS could correctly re-price submitted claims and enable Medicare contractors to settle cost reports.¹⁰

Reconciliation Process

After the end of the cost-reporting period, the hospital compiles the cost report from which the actual CCR for that cost-reporting period can be computed. The actual CCR may be different than the CCR from the most recently settled or most recent tentative settled cost report that was used to calculate individual outlier claim payments during the cost-reporting period. If a hospital's total outlier payments during the cost-reporting period exceed \$500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during that period to calculate outlier payments, CMS policy requires the Medicare contractor to refer the hospital's cost report to CMS for reconciliation (*Medicare Claims Processing Manual* (Claims Processing Manual), chapter 3, § 20.1.2.5). For this report, we refer to the process of determining whether a cost report qualifies for referral as the "reconciliation test."

If the criteria for reconciliation are not met, the Medicare contractor finalizes the cost report and issues an NPR to the hospital. If these criteria are met, the Medicare contractor refers the cost report to CMS at both the central and regional levels.

CMS Transmittal 707¹¹ provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until

⁷ CMS, *Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital [LTCH] Prospective Payment Systems*, 68 Fed. Reg. 34494 (Jun. 9, 2003).

⁸ CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003).

⁹ CMS had projected that it would pay approximately \$17.6 billion for Medicare IPPS outlier payments but actually made approximately \$26.6 billion in payments.

¹⁰ Although CMS did not instruct Medicare contractors to refer hospital cost reports in need of reconciliation until 2005, the 2003 regulations were applicable to cost-reporting periods beginning on or after October 1, 2003.

¹¹ CMS, "IPPS Outlier Reconciliation," Claims Processing Manual, Pub. No. 100-04, Transmittal 707 (Change Request 3966; October 12, 2005).

April 1, 2011. In CMS Transmittal 2111,¹² CMS directs the Medicare contractors to assume the responsibility to perform the reconciliations, effective April 1, 2011. CMS Transmittal 2111 also says that contractors should perform reconciliations only if they receive prior approval from CMS. In that document, CMS also states that it had not performed reconciliations because of system limitations.

To process the backlog of cost reports requiring reconciliation, CMS instructed Medicare contractors to submit to CMS, between April 1 and April 25, 2011, a list of hospitals whose cost reports had been flagged for reconciliation¹³ before April 1, 2011. Further, CMS was to grant approval for Medicare contractors to perform reconciliations for those hospitals with open cost reports. Contractors were then to reconcile, by October 1, 2011, outlier claims that had been flagged before April 1, 2011.

CMS Lump Sum Utility Used in Outlier Recalculation

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

Cost Reports on Hold

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

HOW WE CONDUCTED THIS REVIEW

We compared records from CMS’s database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Palmetto had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011. If the cost reports

¹² CMS, *Outlier Reconciliation and Other Outlier Manual Updates for IPPS, OPPOS [Outpatient PPS], IRF [Inpatient Rehabilitation Facility] PPS, IPF [Inpatient Psychiatric Facility] PPS and LTCH PPS*, Claims Processing Manual, Transmittal 2111 (Change Request 7192; December 3, 2010).

¹³ CMS uses the term “flagged” to refer to outlier payments whose reconciliations were backlogged between 2005 and April 1, 2011.

had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and, where necessary, used CMS's database to calculate the amounts due to Medicare or to providers.

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

Appendix B contains details of our audit scope and methodology.

FINDINGS

Of 23 cost reports with outlier payments that qualified for reconciliation, Palmetto referred 15 cost reports to CMS in accordance with Federal guidelines. However, Palmetto did not refer eight cost reports that should have been referred to CMS for reconciliation. Of these, six cost reports had not been settled or had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with these six cost reports and (2) the recalculated outlier payments totaled at least \$18,883,025. We refer to this difference as financial impact.¹⁴ The two remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation; the financial impact of the outlier payments associated with those two cost reports totaled \$1,641,927.

Of the 15 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Palmetto had reconciled the outlier payments associated with 1 cost report by December 31, 2011. However, Palmetto had not reconciled the outlier payments associated with the remaining 14 cost reports. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 13 of the 14 cost reports that were referred but not reconciled was at least \$29,033,914. We also calculated that \$386,996 was due from Medicare to a provider for 1 of the 14 cost reports that were referred but not reconciled. The net financial impact of the outlier payments associated with these 14 cost reports that were referred but not reconciled was therefore at least \$28,646,918 that was due to Medicare.

Because certain providers require specialized recalculations for their outlier payments, we were unable to recalculate 146 of the 1,988 claims associated with the cost reports that we were recalculating and are setting aside \$1,114,473¹⁵ in outlier payments associated with those claims for resolution by Palmetto and CMS.

¹⁴ The financial impacts that we convey in this report take the time value of money into account and thus also include any accrued interest; see also Appendix B.

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

See Appendix C for a summary of the status of the 23 cost reports with respect to referral and reconciliation, as well as the associated dollar amounts due to Medicare or to the provider.

FEDERAL REQUIREMENTS

Federal regulations state that for discharges occurring on or after October 1, 2003, the CCR applied at the time a claim is processed (and outlier payments are made) is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost-reporting period (42 CFR § 412.84(i)(2)).

If a hospital's total outlier payments during the cost-reporting period exceed \$500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during that period to calculate outlier payments, CMS policy requires the Medicare contractor to refer the hospital's cost report to CMS for reconciliation (Claims Processing Manual, chapter 3, § 20.1.2.5).

CMS Transmittal 707 provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until April 1, 2011. In CMS Transmittal 2111, CMS directs the Medicare contractors to assume the responsibility to perform the reconciliations effective April 1, 2011, although the CMS Central Office would determine whether reconciliations would be performed. In this document, CMS also states that it had not performed reconciliations because of system limitations.

Our calculations of the financial impact of the findings developed in this audit took into account the time value of money. Federal regulations for discharges occurring on or after August 8, 2003, state that outlier payments may be adjusted at the time of reconciliation to account for the time value of any underpayments or overpayments (42 CFR § 412.84(m)). The provisions of the Claims Processing Manual that were in effect during our audit period provided guidance on how to apply the time value of money to the reconciled outlier dollar amount. Specifically, these provisions state that the time value of money stops accruing on the day that the CMS Central Office receives notification of a cost report referral from a Medicare contractor (Claims Processing Manual, chapter 3, § 20.1.2.6).

COST REPORTS NOT REFERRED

Of 23 cost reports with outlier payments that qualified for reconciliation, Palmetto referred 15 cost reports to CMS in accordance with Federal guidelines. However, Palmetto did not refer eight cost reports that should have been referred to CMS for reconciliation.

Cost Reports Within the 3-Year Reopening Limit

Of the eight cost reports that Palmetto did not refer to CMS for reconciliation, six had not been settled or were settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. Palmetto did not refer the six cost reports to CMS because Palmetto had not established adequate control procedures to ensure that all cost reports whose

outlier payments qualified for reconciliation were correctly identified and referred to CMS.¹⁶ As a result of the inadequacy of these control procedures:

- Palmetto did not perform the reconciliation test to identify and refer three cost reports that qualified for reconciliation, and
- Palmetto did not refer three other cost reports that qualified for reconciliation even though Palmetto correctly performed the reconciliation test and recognized that they qualified for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these six unreferred cost reports totaled at least \$18,883,025 that was due to Medicare.

Cost Reports Outside the 3-Year Reopening Limit

Of the eight cost reports that Palmetto did not refer to CMS for reconciliation, the remaining two cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. Palmetto did not refer one of the two cost reports to CMS because the cost report had exceeded the 3-year reopening limit by the time Palmetto became the Medicare contractor responsible for it. Palmetto did not refer the other cost report to CMS because Palmetto had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified; were referred to CMS; and if necessary, were reopened before the 3-year reopening limit. As a result of the inadequacy of these control procedures, Palmetto did not perform the reconciliation test to identify and refer this cost report that qualified for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these two cost reports totaled at least \$1,641,927 that may be due to Medicare.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 15 referred cost reports whose outlier payments qualified for reconciliation, Palmetto reconciled the outlier payments associated with 1 cost report by December 31, 2011. However, Palmetto did not reconcile the outlier payments associated with 14 cost reports by December 31, 2011. The statuses of the cost reports with unreconciled outlier payments were as follows:

- six cost reports were on hold because CMS had not calculated revised SSI ratios and
- eight cost reports had been correctly referred but were still being processed before final settlement (five cost reports had received CMS approval and were undergoing the reconciliation process, one was pending updates to the FISS Lump Sum Utility software,

¹⁶ Five of these cost reports were also on hold because of the SSI-related litigation discussed in “Background.”

and two were on hold because the providers had appealed the time-value-of-money calculations).

For the five cost reports that had received CMS approval and were undergoing the reconciliation process, Palmetto's policies and procedures did not ensure that it reconciled all outlier payments associated with all referred cost reports that qualified for reconciliation in accordance with Federal guidelines. For the other nine cost reports that were referred but whose outlier payments had not been reconciled, CMS bore principal responsibility for the delays that we have described above.¹⁷

For the 14 referred cost reports whose outlier payments Palmetto did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least \$29,033,914 that was due to Medicare (13 cost reports) and \$386,996 that was due to a provider (1 cost report).¹⁸

CLAIMS THAT COULD NOT BE RECALCULATED

The 8 cost reports that were not referred included 146 claims with \$1,114,473 in associated outlier payments. We were unable to recalculate these claims either because we could not verify the original outlier payment calculation for particular claims or because the claims were for certain providers (that is, rehabilitation providers) that required specialized recalculations. We are therefore setting aside the \$1,114,473 for resolution by Palmetto and CMS. We are separately providing detailed data on the claims that we could not recalculate to Palmetto.

FINANCIAL IMPACT TO MEDICARE

As of December 31, 2011, the financial impact of the outlier payments associated with the six unreferred cost reports that were within the 3-year reopening limit was at least \$18,883,025 that was due to Medicare. These cost reports should have been referred to CMS for reconciliation but were not and were also not reconciled even though their outlier payments qualified for reconciliation.

Also as of December 31, 2011, the financial impact of the outlier payments associated with the two cost reports that exceeded the 3-year reopening limit and that should have been referred to CMS for reconciliation but were not was at least \$1,641,927 that may be due to Medicare.

Finally, for the 14 referred cost reports whose outlier payments Palmetto did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least \$29,033,914 that was due to Medicare (13 cost reports) and \$386,996 that was due to a provider (1 cost report). Therefore, the net financial impact to Medicare of the 14 cost reports with unreconciled outlier payments was at least \$28,646,918.

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

¹⁸ As stated in "Findings," the net financial impact of the outlier payments associated with these 14 cost reports that were referred but not reconciled was at least \$28,646,918 that was due to Medicare.

RECOMMENDATIONS

We recommend that Palmetto:

- review the 6 cost reports that had not been settled or had been settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup \$18,883,025 in funds and associated interest from health care providers, and refund that amount to the Federal Government;
- review the 2 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not; determine whether these cost reports may be reopened; and work with CMS to resolve \$1,641,927 in funds and associated interest from health care providers that may be due to the Federal Government;
- review the 14 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
 - reconcile the \$29,033,914 in associated outlier payments due to the Federal Government (13 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and
 - reconcile the \$386,996 in associated outlier payments due from Medicare to a provider (1 cost report), finalize that cost report, and return the funds to the provider;
- work with CMS to resolve the \$1,114,473 in outlier payments associated with the 146 claims that we could not recalculate;
- strengthen control procedures to ensure that all cost reports whose outlier payments qualify for reconciliation are correctly identified, referred, and, if necessary, reopened before the 3-year reopening limit;
- strengthen policies and procedures to ensure that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Palmetto disagreed with our findings and did not concur with our recommendations. A summary of Palmetto's comments and our response follows.

Palmetto's comments, excluding 155 pages that we have removed from this final report because of their volume and because they contain both proprietary and personally identifiable information, appear as Appendix D. We have also redacted proprietary information (regarding third parties) within Appendix D. We are separately providing Palmetto's comments in their entirety to CMS.

On the basis of Palmetto's comments and its additional documentation, we revised a portion of our discussion of one finding (involving one unrefereed cost report that was outside the 3-year reopening limit). Otherwise, we maintain that all of our findings, and the associated recommendations, remain valid.

COST REPORTS NOT REFERRED

Cost Reports Within the 3-Year Reopening Limit

Auditee Comments

With respect to our finding that Palmetto did not refer six cost reports that should have been referred to CMS for reconciliation, Palmetto stated that the Claims Processing Manual, chapter 3, section 20.1.2.5, does not specify a timeframe within which a cost report that requires reconciliation has to be referred to CMS. Palmetto also stated that this manual provision mandates that it first complete a "desk review" and conduct any necessary audit activity of a submitted cost report in order to identify any required adjustments before it, Palmetto, can perform the reconciliation test.¹⁹ Palmetto added that the timing of the desk review and audit activity depends on its audit budget, work plan, and CMS instructions regarding when NPRs can be released because of the DSH/SSI hold.

Office of Inspector General Response

We maintain that our findings and the associated recommendations regarding the six unrefereed cost reports remain valid. Palmetto's written comments confirmed that the six unrefereed cost reports that were within the 3-year reopening limit and that qualified for reconciliation had not been referred to CMS as of December 28, 2010 (the start of our audit), as we state earlier in this report.

We agree with Palmetto that chapter 3, section 20.1.2.5, of the Claims Processing Manual does not specify a timeframe within which a cost report that requires reconciliation has to be referred to CMS. However, CMS Transmittal 2111 instructed Medicare contractors to submit to CMS, between April 1 and April 25, 2011, a list of hospitals whose cost reports had been flagged for reconciliation before April 1, 2011 (footnote 13). Palmetto confirmed in its comments that three of the six cost reports had been flagged for reconciliation by a previous contractor before being transferred to Palmetto on December 28, 2010, as part of the J11 MAC transition. Palmetto did

¹⁹ The actions that Palmetto referred to as "desk review" may, for purposes of this report, be regarded as those which we term "preliminary review." (See "Background.")

not refer these three cost reports to CMS for outlier reconciliation until February 27, 2012, November 8, 2012, and November 16, 2012, respectively.

The other three cost reports also were transferred to Palmetto on December 28, 2010, but the previous contractor had not performed a reconciliation test on any of them. Palmetto confirmed in its comments that it did not complete desk reviews of these reports until May 2012 and did not refer these reports to CMS for reconciliation until June 7, 2013, February 18, 2014, and November 30, 2012, respectively. Although chapter 3, section 20.1.2.5, of the Claims Processing Manual does not specify a timeframe within which a cost report that requires reconciliation has to be referred to CMS, CMS has established timeframes within which Medicare contractors must settle cost reports and issue NPRs:

- The PRM-1, chapter 29, section 2905, states that Medicare contractors must issue NPRs “within a reasonable period of time.”
- The PRM-1, chapter 29, section 2905.1, states that Medicare contractors are to “make every attempt to issue a NPR within 12 months of receipt of a cost report.”
- Chapter 8, section 90, of the *Medicare Financial Management Manual* states that CMS expects Medicare contractors to settle all cost reports that are not scheduled for audit within 12 months of acceptance of the cost report unless there is a documented reason why the cost report cannot be settled.

To meet the 12-month deadline, tentative adjustments are made “as soon as [a] cost report is received” by a Medicare contractor (PRM-1, chapter 24, § 2408.2), and the Medicare contractor has 30 days from the date of receipt of a provider’s cost report to make a determination of acceptability (PRM-2, chapter 1, § 140). Moreover, the objective of “desk reviews” is to determine whether a cost report can be settled without an audit (*Medicare Financial Management Manual*, chapter 8, § 20.1). We are not aware of any exceptions, in any of these CMS guidelines, that permit a Medicare contractor to delay activities, such as desk reviews and cost report settlements, because of its audit budget or work plan.

In addition, we recognize that Palmetto could not issue a final NPR until the DSH/SSI hold had been lifted.²⁰ Nevertheless, CMS instructions regarding cost reports subject to the DSH/SSI hold do not state that Medicare contractors are to forego performing desk reviews or reconciliation tests before the DSH/SSI hold is lifted. In fact, Palmetto confirmed in its comments that it completed or tried to complete reconciliations of six other cost reports that were subject to the DSH/SSI hold before the hold was lifted and added that it had received extensions from CMS to perform some of those reconciliations for reasons other than the DSH/SSI hold.

Finally, and as discussed in “Federal Requirements,” our calculations of the financial impact of our findings took into account the time value of money (i.e., interest). Because these calculations are based on the cost report referral dates, delays in referring a cost report that

²⁰ See “Cost Reports on Hold” earlier in this report.

qualifies for reconciliation increase the amounts due from providers to Medicare or due from Medicare to providers. Therefore, Medicare contractors should identify cost reports that qualify for reconciliation and refer them to CMS as soon as possible to avoid the unnecessary accrual of additional costs due to Medicare or to providers.

Cost Reports Outside the 3-Year Reopening Limit

Auditee Comments

Our report identifies two unrefereed cost reports that had exceeded the 3-year reopening limit. Palmetto disagreed with both of these findings. For the first of these (for which we said that Palmetto did not perform the reconciliation test), Palmetto stated that the cost-reporting period for that provider was not under the jurisdiction of either Palmetto or the previous Medicare contractor. For the second cost report, Palmetto stated that the prior Medicare contractor had settled the cost report and that the 3-year reopening limit had passed by the time responsibility for this cost report had transferred to Palmetto. Moreover, Palmetto disagreed with our recommendation to reopen the second cost report. Palmetto said that, except in cases of fraud, cost reports cannot be reopened beyond 3 years after the date of their final settlement.

Office of Inspector General Response

With respect to the first of the two unrefereed cost reports that had exceeded the 3-year reopening limit, we disagree with Palmetto's statement that the cost-reporting period for that provider was not under Palmetto's jurisdiction. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare contractors and codified in statute the revised process that is also known as Medicare contracting reform. Under this legislation, CMS enters into contracts with Palmetto and other Medicare contractors to administer claims for providers that are located within designated geographic areas. This legislation also states that Medicare contractors (such as Palmetto) that either won new Medicare contracts; retained the contracts that they had before implementation of this legislation; or gained new jurisdictions, providers, or both because of shifts in responsibilities become responsible for the providers and cost reports that were under the jurisdiction of the previous fiscal intermediaries, carriers, and Medicare contractors. Palmetto did not originally have jurisdiction over this particular provider (that is, before the transition in responsibilities). However, as the Medicare contractor since 2011 for Jurisdiction 11 (in which the provider for this unrefereed cost report is physically located), Palmetto now services this provider, can access the needed information through CMS, and is therefore responsible for resolving our recommendations associated with that cost report.

With respect to the second of the two unrefereed cost reports that had exceeded the 3-year reopening limit, we revised a portion of our discussion of that finding on the basis of additional documentation that Palmetto provided.

Regarding the cost reports that had exceeded the 3-year reopening limit, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "fraud or similar fault." Specifically, 42 CFR § 405.1885(b)(3) provides that a Medicare payment contractor (e.g.,

Palmetto) may reopen an initial determination *at any time* if the determination was procured by fraud or similar fault. For example, a Medicare payment contractor may reopen a cost report after determining that a provider received money that it knew or reasonably should have known it was not entitled to retain (73 Fed. Reg. 30190, 30233 (May 23, 2008)). Because the outlier reconciliation rules are promulgated in Federal regulations, providers knew or should have known the rules when their cost reports were settled. We believe that these regulations constitute a sufficient basis for our second recommendation and recognize that ultimately, CMS, as the cognizant Federal agency, has the authority to decide how to resolve these and the other recommendations in this audit report. Accordingly, we continue to recommend that Palmetto determine whether these two providers procured Medicare funds by “similar fault” and work with CMS to resolve their \$1,641,927 in outlier payments.

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Auditee Comments

With respect to our finding that Palmetto did not reconcile the outlier payments associated with 14 cost reports whose outlier payments qualified for reconciliation,²¹ Palmetto disagreed with our decision to set December 31, 2011, as the cutoff date by which Palmetto was to reconcile the referred cost reports (footnote 3). Specifically, Palmetto stated that it had not reconciled all of the cost reports as of December 31, 2011, because CMS had granted extensions for cost reports that (1) were on hold for SSI-related litigation, (2) had been approved by CMS for reconciliation and were undergoing the reconciliation process, (3) were pending updates to the FISS Lump Sum Utility software, or (4) involved cases in which providers had appealed the time-value-of-money calculations.

Palmetto also disagreed with our position that a cost report must have been brought to final settlement (i.e., the NPR issued to the hospital) for the reconciliation process to be considered complete. Palmetto said that it considered “... the outlier reconciliation process to be complete when all claims had been re-priced and the appropriate cost report adjustment determined.”

Office of Inspector General Response

We determined the status of the reconciliation process for each cost report as of December 31, 2011. While our selection of December 31, 2011, as a cutoff date provided a 3-month grace period beyond the CMS-established deadline of October 1, 2011, our report provides a status update and does not opine as to whether the cost reports were reconciled in accordance with any CMS-established deadlines or extensions. Furthermore, our report notes that CMS bore principal responsibility for the delays associated with any cost reports that (1) were on hold for SSI-related litigation, (2) had been approved by CMS for reconciliation and were undergoing the reconciliation process, (3) were pending updates to the FISS Lump Sum Utility software, or (4) involved cases in which providers had appealed the time-value-of-money calculations.

²¹ The 14 cost reports in this finding are associated with our third recommendation.

We disagree with Palmetto's position regarding when the reconciliation process is considered to be complete. We considered the reconciliation process for a particular cost report to have been completed if all claims had been correctly re-priced and the cost report itself had been brought to final settlement (i.e., the Medicare contractor had issued the NPR). This approach conforms to CMS guidance (Claims Processing Manual, chapter 3, § 20.1.2.7, step 13).²² Our report focused on the completion of the reconciliation process and not just on the recalculation of the outlier payments associated with a cost report.

In light of these considerations, we continue to maintain that our findings regarding the 14 referred cost reports remain valid and continue to recommend that Palmetto review these cost reports and work with CMS to reconcile the associated outlier payments.

PROCEDURAL RECOMMENDATIONS

Our first four recommendations are associated with our findings involving unreferral cost reports, cost reports that had been referred but whose outlier payments had not been reconciled, and claims that we could not recalculate; there are financial impacts and dollar amounts associated with each of these recommendations. Our last three recommendations are procedural in nature and do not have associated financial impacts or dollar amounts.

Auditee Comments

Palmetto did not concur with our last three recommendations, which are procedural. Palmetto stated that its comments gave evidence that it already had adequate control procedures in place to ensure that all cost reports whose outlier payments qualified for reconciliation were identified, referred, and reconciled after receiving approval from CMS.

Office of Inspector General Response

Our findings and our responses to Palmetto's comments show that Palmetto's control procedures regarding cost report referral and its policies and procedures for reconciliation of outlier payments were not always adequate. Measures to strengthen these procedures would bring Palmetto into closer compliance with CMS policies and requirements regarding cost report referral and reconciliation of outlier payments. These measures would also contribute to the successful implementation of our final recommendation. We therefore maintain that all of our procedural recommendations remain valid and provide precise, focused, and actionable measures through which Palmetto, in concert with CMS, can address and resolve our findings.

²² This has been step 13 of the manual provision since Transmittal 2111 (December 3, 2010). Before that and during our audit period, it was step 6 in Transmittal 707 (October 12, 2005) and step 8 in Transmittal 1072 (Change Request 5286; October 6, 2006).

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>National Government Services, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 8</i>	A-05-11-00046	March 2015
<i>Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02774	December 2014
<i>Wisconsin Physicians Service Insurance Corporation Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-10-02777	November 2014
<i>Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments</i>	A-07-11-02773	October 2014
<i>TrailBlazer Health Enterprises Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required</i>	A-07-10-02776	June 2014
<i>The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance</i>	A-07-10-02764	June 2012

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Palmetto had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.²³ If the cost reports had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and calculated the amounts due to Medicare or to providers.

We performed audit work in our Denver, Colorado, field office, from December 2010 to January 2014.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to Palmetto and other Medicare contractors concerning the reconciliation process and responsibilities;
- obtained from CMS a list of cost reports that Medicare contractors had referred for reconciliation;
- held discussions with Palmetto officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed Palmetto's policies and procedures regarding referral to CMS and reconciliation of cost reports;
- reviewed provider lists from all Medicare contractors to determine which providers were under Palmetto's jurisdiction as of December 28, 2010 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that Palmetto had referred to CMS for reconciliation during our audit period;

²³ Although the CMS-established deadline for reconciling the cost reports was October 1, 2011, for this review we provided a 3-month grace period by establishing December 31, 2011, as our cutoff date.

- obtained the cost report data from CMS’s database for cost reports with fiscal-year ends during our audit period;
- obtained the Inpatient Acute Care and LTCH provider specific files (PSFs) from the CMS Web site;
- determined which cost reports qualified for reconciliation by:
 - using the information in a CMS database to identify acute-care and long-term-care cost reports that had greater than \$500,000 in outlier payments²⁴ and
 - using the information in CMS’s database and PSF data to calculate and compare the actual and weighted average CCRs to determine whether the resulting variance was greater than 10 percentage points;
- verified that Palmetto used the three different types of outlier payments specified by Federal regulations²⁵ (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;
- requested that Palmetto provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;²⁶
- reviewed Palmetto’s response and categorized the cost reports according to their respective statuses;
- verified whether Palmetto had referred the cost reports before the date of the audit notification letter;
- verified that all of the cost reports we reviewed met the criteria for reconciliation;
- performed the following actions for cost reports that qualified for outlier reconciliation but for which Palmetto did not recalculate the outlier payments:
 - obtained the detailed Provider Statistical & Reimbursement reports from Palmetto or obtained the National Claims History data from CMS;

²⁴ CMS cost report data included operating and capital payments but did not include short-stay outlier payments.

²⁵ Claims Processing Manual, chapter 3, § 20.1.2.5.

²⁶ Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by Palmetto.

- verified the original outlier payments using the CCR that was used to pay the claim;²⁷
 - recalculated the outlier payment amounts for those cost reports that Palmetto did not recalculate using the actual CCRs;
 - identified those claims that we were unable to recalculate either because we could not verify the original outlier payment calculation for particular claims, because the claims were for providers that required specialized recalculations, or because some of the CCRs from the CMS database were so anomalous as to be of questionable reliability; and
 - calculated accrued interest²⁸ as of the date that the cost report was referred to CMS (for unreferred cost reports or those that were referred after December 31, 2011, we calculated the amount of accrued interest as of December 31, 2011);
- summarized the results of our analysis including the total amount due to or from Medicare; and
 - provided the results of our review to Palmetto officials on January 30, 2014.

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

²⁷ We set aside claims whose original outlier payments we could not verify.

²⁸ We calculated interest by referring to the Claims Processing Manual, chapter 3, § 20.1.2.6.

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

Table 1: Total Cost Reports and Amounts Due

Grand Total	Due to Medicare	Due to Provider
23 Cost Reports	\$49,558,866	\$1,145,294

Table 2: Cost Reports Not Referred (OIG Identified)

Cost Report Category	Reconciled	Not Reconciled			Not Reconciled Subtotal	Total
		Within 3 Years		Past 3 Years		
		In Process	On Hold			
Number of Cost Reports	0	1	5	2	8	8
Balance Due to Medicare	0	\$1,032,907	\$14,283,832	\$1,254,490	\$16,571,229	\$16,571,229
Interest Due to Medicare	0	298,475	3,267,811	387,437	3,953,723	3,953,723
Balance Due to Provider	0	0	0	0	0	0
Interest Due to Provider	0	0	0	0	0	0
Total Due to Medicare	0	\$1,331,382	\$17,551,643	\$1,641,927	\$20,524,952	\$20,524,952
Total Due to Provider	0	0	\$0	\$0	\$0	\$0

Note: The dollar amounts associated with these cost reports do not reflect the 146 claims that we were unable to recalculate.

Table 3: Cost Reports Referred (Medicare Contractor Identified)

Cost Report Category	Reconciled	Not Reconciled			Not Reconciled Subtotal	Total
		Within 3 Years		Past 3 Years		
		In Process	On Hold			
Number of Cost Reports	1	8	6	0	14	15
Balance Due to Medicare	\$0	\$17,270,716	\$8,101,321	\$0	\$25,372,037	\$25,372,037
Interest Due to Medicare	0	2,353,291	1,308,586	0	3,661,877	3,661,877
Balance Due to Provider	703,404	0	334,997	0	334,997	1,038,401
Interest Due to Provider	54,894	0	51,999	0	51,999	106,893
Total Due to Medicare	\$0	\$19,624,007	\$9,409,907	\$0	\$29,033,914	\$29,033,914
Total Due to Provider	\$758,298	\$0	\$386,996	\$0	\$386,996	\$1,145,294

APPENDIX D: AUDITEE COMMENTS

PO BOX 100144 | COLUMBIA, SC 29202-3144 | PALMETTOGBA.COM/J11 | ISO 9001

A/B MAC JURISDICTION 11
North Carolina, South Carolina, Virginia, West Virginia, Home Health and Hospice



June 6, 2014

Patrick J. Cogley
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: REPORT A-07-10-02775

Dear Mr. Cogley:

Enclosed are Palmetto GBA's comments and supporting documents in response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled *Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required in Jurisdiction 11*. We have included our views on the validity of the facts and reasonableness of the findings and recommendations in this report.

If you have questions about any of the enclosed information or documents, please do not hesitate to contact me at (803) 763-5526 or Pat Anderson at (803) 382-6276.

Sincerely,

Scott Neely
Director, Provider Audit and Reimbursement J11
Palmetto GBA

Enclosures

cc: Ed Sanchez, Vice President, J11 Operations, Palmetto GBA
Pat Anderson, Manager, Provider Audit J11, Palmetto GBA

AU-Letterhead MAC Form
Revision 6 04/25/2014

State Administrator or Contractor



Response to OIG Findings and Recommendations
Palmetto J11 Medicare Outlier Reconciliation Processing Timeliness
A-07-10-02775

Palmetto GBA Comments

Upon issuance of CMS Transmittal 707 (Change Request 3966) on October 12, 2005, Palmetto GBA (Palmetto) established procedures to review all applicable hospital cost reports to determine if a reconciliation of outlier payments was required, and, to refer cost reports that required a reconciliation to CMS (See Exhibit 1). Those procedures were established based on CMS performing the outlier reconciliation. Upon issuance of CMS Transmittal 2111 (Change Request 7192) on December 3, 2010, Palmetto updated its procedures as this change request required that contractors, rather than CMS, perform the outlier reconciliation after receiving approval from CMS (See Exhibit 2). All procedures are posted in Palmetto's Quality Management System (QMS). As will be documented in the following responses, Palmetto had adequate control procedures in place that were followed to ensure that all cost reports whose outlier payments required reconciliation were correctly identified, referred to CMS, and reconciled after receiving approval from CMS.

To support our concurrence or nonoccurrence with the recommendations in the U.S Department of Health and Human Services, Office of Inspector General (OIG) draft report, we will address the validity of the facts and findings used as the basis for the recommendations. Palmetto offers the following responses to the Findings in the OIG draft report. As additional insight into our responses please note that Palmetto GBA is the Medicare Administrative Contractor (MAC) for Jurisdiction 11, which includes the states of North Carolina, South Carolina, Virginia and West Virginia. In January 2011, most providers in the state of North Carolina transferred to Palmetto as part of the J11 transition. Most providers located on the states of Virginia and West Virginia transferred to Palmetto in May 2011. Prior to those dates, the providers in those three states were the responsibility of different contractors. Most providers in the state of South Carolina had been previously assigned to Palmetto.

OIG FINDING

COST REPORTS NOT REFERRED

Of 23 cost reports with outlier payments that qualified for reconciliation, Palmetto referred 15 cost reports to CMS in accordance with Federal guidelines. However, Palmetto did not refer eight cost reports that should have been referred to CMS for reconciliation.

Cost Reports Within the 3-Year Reopening Limit

Of the eight cost reports that Palmetto did not refer to CMS for reconciliation, six had not been settled or were settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation. Palmetto did not refer the six cost reports to CMS because Palmetto had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified and referred to CMS. As a result of the inadequacy of these control procedures:

Response to OIG Findings and Recommendations
Palmetto J11 Medicare Outlier Reconciliation Processing Timeliness
A-07-10-02775

- Palmetto did not perform the reconciliation test to identify and refer three cost reports that qualified for reconciliation, and
- Palmetto did not refer three other cost reports that qualified for reconciliation even though Palmetto correctly performed the reconciliation test and recognized that they qualified for reconciliation.

PALMETTO RESPONSE TO FINDING

Cost Reports Within the 3-Year Reopening Limit

Business Requirement 7192.13 of CMS Transmittal 2111 (Change Request 7192) issued on December 3, 2010 required that contractors submit a list of providers that were flagged for outlier reconciliation prior to April 1, 2011. The OIG outlier audit began on December 28, 2010. The OIG has taken the position that the eight (8) cost reports that had not been referred to CMS for outlier reconciliation at the start of its audit on December 28, 2010, or by April 1, 2011 were not referred in accordance with Federal guidelines.

CMS manual instructions do not specify a date or timeframe for when a cost report that requires a reconciliation of outlier payments has to be referred to CMS. CMS Publication 100-4, Chapter 3, Section 20.1.2.5, states, in part:

“To determine if a hospital meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual operating CCR prior to issuing a Notice of Program Reimbursement (NPR).”

All adjustments to a cost report cannot be determined until after all desk review and, if applicable, audit activity has been completed. Palmetto performed the outlier reconciliation tests after all desk review and, if applicable, audit activity had been completed.

Palmetto’s timing of completing the desk review and audit activity and performing the outlier reconciliation test was based on its audit budget, work plan, and CMS instructions on when NPRs could be released due to the DSH/SSI hold. At April 1, 2011, the desk review had not been completed on three of the eight cost reports included in this finding (See Exhibit 3). Therefore, the outlier reconciliation test could not be completed on these reports at April 1, 2011.

The details of Palmetto’s actions taken on each of the eight cost reports identified by the OIG as having not been referred to CMS are listed below.

- **Response to** – “Palmetto did not perform the reconciliation test to identify and refer three cost reports that qualified for reconciliation.”

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Palmetto does not agree with this finding. The outlier reconciliation tests on the three cost reports identified below were completed within the parameters established within CMS Publication 100-4, Chapter 3, Section 20.1.2.5.

²⁹
REDACTED **FYE 9/30/08** This cost report was transferred from the outgoing contractor to Palmetto on December 28, 2010 as part of the J11 MAC transition. The desk review of this cost report was not complete at the start of the OIG audit on December 28, 2010, or at April 1, 2011; therefore, the outlier reconciliation test had not been performed and the cost report had not been referred to CMS. The desk review of the cost report was completed on May 19, 2012 (See Exhibit 3). The outlier reconciliation test was performed at the time that cost report could be released for SSI settlement based on CMS Transmittal 1096 (CR 7814 issued 6/8/12), CMS Technical Direction Letter (TDL) 13105 issued 12/7/12, and CMS TDL 13179 issued on 1/30/13 (See Exhibit 4). The outlier reconciliation test was completed on May 14, 2013 (See Exhibit 5). The cost report was referred to CMS on June 7, 2013 (See Exhibit 6). Palmetto is still awaiting CMS approval to perform the outlier reconciliation.

REDACTED **FYE 6/30/06** This cost report was transferred from the outgoing contractor to Palmetto on December 28, 2010 as part of the J11 MAC transition. The desk review of this cost report was not complete at the start of the OIG audit on December 28, 2010, or at April 01, 2011; therefore, the outlier reconciliation test had not been performed and the cost report had not been referred to CMS. The desk review of the cost report was completed on May 20, 2012 (See Exhibit 3). The outlier reconciliation test was completed on February 18, 2014 (See Exhibit 7). The cost report was referred to CMS on February 18, 2014 (See Exhibit 8). Palmetto is still awaiting CMS approval to perform the outlier reconciliation. (The cost report cannot be settled due to the CMS hold on the 2005 SSI%.)

REDACTED **FYE 6/30/07** This cost report was transferred from the outgoing contractor to Palmetto on December 28, 2010 as part of the J11 MAC transition. The desk review of this cost report was not complete at the start of the OIG audit on December 28, 2010, or at April 01, 2011; therefore, the reconciliation test had not been performed and the cost report had not been referred to CMS. The desk review of the cost report was completed on May 20, 2012 (See Exhibit 3). The outlier reconciliation test was completed at the time that cost report could be released for SSI settlement based on CMS Transmittal 1096 (CR 7814 issued 6/8/12), CMS Technical Direction Letter (TDL) 13105 issued 12/7/12, and CMS TDL 13179 issued on

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²⁹ Office of Inspector General Note—The deleted text has been redacted because it is proprietary information.

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1/30/13 (See Exhibit 4). The outlier reconciliation test was completed on September 6, 2012 (See Exhibit 9). The hospital **REDACTED** and the IRF subunit **REDACT** were referred to CMS on November 30, 2012 (See Exhibits 10 and 11). Palmetto has received approval to complete the outlier reconciliation for the IRF subunit, but, is still awaiting CMS approval to perform the outlier reconciliation for the hospital.

- **Response to** – “Palmetto did not refer three other cost reports that qualified for reconciliation even though Palmetto correctly performed the reconciliation test and recognized that they qualified for reconciliation.”

Palmetto does not agree with this finding. Palmetto was not the contractor for the providers identified below during the period in which the providers should have been referred to CMS for outlier reconciliation. After the providers were transferred to Palmetto the providers were referred to CMS for outlier reconciliation in accordance with our established policies and procedures.

REDACTED **FYE 12/31/06** This cost report was transferred to Palmetto on December 28, 2010 as part of the J11 MAC transition. The cost report was settled by the previous contractor on December 22, 2008. The previous contractor performed the outlier reconciliation test on October 30, 2008 and determined that a reconciliation of outlier payments was required (See Exhibit 12). However, the previous contractor did not refer the cost report to CMS for outlier reconciliation. On June 13, 2011, Palmetto issued a letter of intent to reopen the cost report in order to meet the 3-year reopening limit (See Exhibit 13). On February 27, 2012 Palmetto referred the cost report to CMS for outlier reconciliation (See Exhibit 14). Palmetto is still awaiting CMS approval to perform the outlier reconciliation.

REDACTED **FYE 9/30/07** This cost report was transferred to Palmetto on December 28, 2010 as part of the J11 MAC transition. The previous contractor performed the outlier reconciliation test on August 24, 2010 and determined that a reconciliation of outlier payments was required (See Exhibit 15). However, the previous contractor did not refer the cost report to CMS for outlier reconciliation. On November 8, 2012 Palmetto referred the cost report to CMS for outlier reconciliation (See Exhibit 16). Palmetto is still awaiting CMS approval to perform the outlier reconciliation.

REDACTED **FYE 9/30/07** This cost report was transferred to Palmetto on December 28, 2010 as part of the J11 MAC transition. The outlier reconciliation test was performed by the previous contractor **REDACT** December 17, 2010 (See Exhibit 17). During the J11 MAC transition, Palmetto received a listing of cost reports that had been referred to CMS for

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outlier reconciliation by the outgoing contractor; this cost report was included on the listing (See Exhibit 18). However, the audit files received by Palmetto from the outgoing contractor did not include documentation of the referral to CMS. On November 16, 2012 Palmetto referred the cost report to CMS for outlier reconciliation (See Exhibit 19). On January 25, 2013 CMS approved the request to perform the outlier reconciliation (See Exhibit 20). The outlier reconciliation was performed on February 5, 2014 (See Exhibit 21). The claims (146) that included \$1,068,326 in outlier payments were re-priced based on the CCR from the adjusted cost report. The total recouped from the provider related to the outlier reconciliation was \$830,194; the recoupment includes the time value of money. The NPR was issued on 5/20/2014.

OIG FINDING

Cost Reports Outside the 3-Year Reopening Limit

Of the eight cost reports that Palmetto did not refer to CMS for reconciliation, the remaining two cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. Palmetto did not refer the two cost reports to CMS because Palmetto had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified, were referred to CMS, and, if necessary, were reopened before the 3-year reopening limit. As a result of the inadequacy of these control procedures:

- Palmetto did not perform the reconciliation test to identify and refer one cost report that qualified for reconciliation,
- Palmetto correctly performed the reconciliation test and recognized that one cost report qualified for reconciliation but did not then refer it to CMS.

PALMETTO RESPONSE TO FINDING

Cost Reports Outside the 3-Year Reopening Limit

The details of Palmetto's actions taken on each of the two cost reports that had exceeded the 3-year reopening limit are listed below.

- **Response to** – “Palmetto did not perform the reconciliation test to identify and refer one cost report that qualified for reconciliation,”

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REDACTED FYE 5/31/04 Palmetto does not agree with this finding. This cost reporting period is not under the jurisdiction of Palmetto or the previous contractor. Based on information in the CMS System for Tracking Audit and Reimbursement (STAR), the FI / MAC number for the cost report for **REDACTED** FYE 5/30/04 is **REDACTED** **REDACTED** (See Exhibit 22).

As Palmetto GBA is not the contractor for this cost reporting period, Palmetto does not have access to claims data or the cost report for **REDACTED** or the FYE 5/31/04 (See Exhibits 23 and 24). Therefore, Palmetto **cannot** perform any review of outlier payments for this cost report. The first cost report for **REDACTED** submitted to the previous contractor and ultimately transferred to Palmetto, covered the period 6/1/04 through 6/30/05 (See Exhibit 24).

REDACTED is contractor responsible for the review of outlier payments for the **REDACTED** FYE 5/31/04 cost report, we recommend OIG work **REDACTED** to determine whether the outlier reconciliation process was completed for this cost report.

- **Response to** – “Palmetto correctly performed the reconciliation test and recognized that one cost report qualified for reconciliation but did not then refer it to CMS.”

REDACTED FYE 9/30/06 Palmetto does not agree with this finding. This cost report was transferred to Palmetto on December 28, 2010 as part of the J11 MAC transition. The cost report was settled by the previous contractor on September 10, 2007. The previous contractor did not complete the outlier reconciliation test or refer the cost report to CMS prior to settling the cost report.

The 3-year deadline for requesting a reopening of this cost report was September 10, 2010. The reopening deadline had already passed before Palmetto received the files from the outgoing contractor on December 28, 2010 as part of the J11 MAC transition. Except in cases of fraud, cost reports cannot be reopened beyond three (3) years after the date of settlement of the cost report. Since the outlier reconciliation is not a fraud issue, the cost report cannot be reopened beyond three years after the date of settlement of the cost report.

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OIG FINDING

COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED

Of the 15 referred cost reports whose outlier payments qualified for reconciliation, Palmetto reconciled the outlier payments associated with 1 cost report by December 31, 2011. However, Palmetto did not reconcile the outlier payments associated with 14 cost reports by December 31, 2011. The statuses of the cost reports with unreconciled outlier payments were as follows:

- 6 cost reports were on hold because CMS had not calculated revised SSI ratios,
- 8 cost reports had been correctly referred but were still being processed before final settlement

PALMETTO RESPONSE TO FINDING

As stated in footnote 3 of the OIG draft report, although the CMS-established deadline for reconciling outlier payments on the cost reports that had been referred to CMS at April 1, 2011 was October 1, 2011, for this review the OIG provided a 3-month grace period by establishing December 31, 2011 as its cutoff date. For this review, the OIG considered the outlier payments to have been reconciled and the reconciliation process to be complete when all claims had been correctly re-priced and the cost report had been brought to final settlement.

Palmetto does not agree with the December 31, 2011 cutoff date since CMS granted extensions past December 31, 2011 to complete the outlier reconciliation on certain cost reports (See Exhibit 25). Also, Palmetto does not agree with the position taken by the OIG that a cost report must have been brought to final settlement (i.e. the Notice of Program Reimbursement (NPR) issued to the hospital) for the outlier reconciliation process to be considered complete. Palmetto considered the outlier reconciliation process to be complete when all claims had been re-priced and the appropriate cost report adjustment determined. As explained below, there are many instances where the outlier reconciliation process is complete, but the cost report cannot be brought to final settlement. Palmetto correctly re-priced all claims, completed the outlier reconciliations, and determined the appropriate cost report adjustments by the CMS due dates on all but one of the cost reports that had been referred to CMS prior to April 1, 2011. But, the NPRs could not be issued due to various other circumstances. The reconciliation had not been completed on one cost report because CMS approval to complete the outlier reconciliation had not been received.

- **Response to** - “6 cost reports were on hold because CMS had not calculated revised SSI ratios:”

REDACTED FYE 9/30/04 CMS granted Palmetto an extension through March 31, 2012 to complete the outlier reconciliation on this cost report (See Exhibit

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25). The reconciliation was completed on March 29, 2012. The NPR is still on hold pending release of the FFY 2004 SSI%.

REDACTED **FYE 6/30/05** CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 12, 2011. The NPR is still on hold pending release of the FFY 2004 SSI%.

REDACTED **FYE 9/30/06** CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 12, 2011. The reopened NPR was issued on May 3, 2013 after CMS approved the release of settlements of cost reports that use the FFY 2006 SSI%.

REDACTED **FYE 9/30/06** CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 12, 2011. The NPR was issued on October 16, 2012 after CMS approved the release of settlements of cost reports that use the FFY 2006 SSI%.

REDACTED **FYE 6/30/07** The cost report was referred to CMS for outlier reconciliation by the previous contract **REDACTED** on April 6, 2009. Palmetto followed up with CMS on February 27, 2012 requesting approval to complete the reconciliation. On November 20, 2012, CMS responded and requested that Palmetto hold off on completing the reconciliation. To date, Palmetto has not received approval from CMS to proceed with the reconciliation.

REDACTED **FYE 9/30/05** CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 13, 2011. The NPR is still on hold pending release of the FFY 2005 SSI%

- **Response to** – “8 cost reports had been correctly referred but were still being processed before final settlement”
 - 5 cost reports had received CMS approval and were undergoing the reconciliation process:

REDACTED **FYE 9/30/05** CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 12, 2011. The reopened NPR was issued on May 18, 2012.

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REDACTED FYE 12/31/05 CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 12, 2011. The reopened NPR was issued on May 18, 2012.

REDACTED FYE 12/31/04 CMS granted Palmetto an extension through March 31, 2012 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on March 26, 2012. The NPR is still on hold pending release of the FFY 2004 SSI%.

REDACTED FYE 6/30/08 CMS granted Palmetto an extension through March 31, 2012 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on March 12, 2012. The NPR was issued November 14, 2012 after CMS approved the release of settlements of cost reports that use the FFY 2007 SSI%.

REDACTED FYE 9/30/07 CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 14, 2011. The NPR was issued October 17, 2012 after CMS approved the release of settlements of cost reports that use the FFY 2007 SSI%.

- 1 was pending updates to the FISS Lump Sum Utility software:

REDACTED FYE 9/30/04 CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 12, 2011. The reopened NPR was issued on May 18, 2012.

- 2 cost reports the provider appealed the time value of money calculations:

REDACTED FYE 6/30/06 CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 14, 2011. The NPR was held due to the provider's appeal to CMS challenging the application of the time value of money. Palmetto is still awaiting CMS approval to release NPR.

REDACTED FYE 6/30/07 CMS granted Palmetto an extension through December 15, 2011 to complete the outlier reconciliation on this cost report (See Exhibit 25). The reconciliation was completed on December 14, 2011. The NPR was held due to the provider's appeal to CMS challenging the application of the time value of money. Palmetto is still awaiting CMS approval to release NPR.

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CLAIMS THAT COULD NOT BE RECALCULATED

OIG FINDING

The eight cost reports that were not referred included 146 claims with \$1,114,473 in associated outlier payments. We were unable to recalculate these claims for certain providers because they required specialized recalculations for their outlier payments. We are therefore setting aside the \$1,114,473 for resolution by Palmetto and CMS. We are separately providing detailed data on the claims that we could not recalculate to Palmetto.

PALMETTO RESPONSE TO FINDING

Based on the spreadsheet received from the OIG, the claims that the OIG could not recalculate were applicable to the following cost reports:

REDACTED	FYE 6/30/06	One (1) claim
REDACTED	FYE 6/30/07	One (1) claim
REDACTED	FYE 9/30/07	144 claims

Palmetto is still awaiting approval from CMS to perform the outlier reconciliation on the **REDACTED** FYE 6/30/07 and FYE 6/30/07 cost reports.

The outlier reconciliation for **REDACTED** FYE 9/30/07 was performed on February 5, 2014 (See Exhibit 21). The detailed PS&R used to perform the reconciliation included 146 claims with a total of \$1,068,326 in outlier payments instead of the \$1,068,326 noted in the report. The claims were re-priced based on the actual CCR from the adjusted cost report. The total recouped from the provider related to the outlier reconciliation was \$830,194; the recoupment includes the time value of money. The NPR was issued on May 20, 2014, which will result in the recoupment identified above.

PALMETTO RESPONSE TO RECOMMENDATIONS

OIG recommends that Palmetto:

- review the 6 cost reports that had not been settled or were settled and reopened within the 3-year reopening limit and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup \$18,883,025 in funds and associated interest from health care providers, and refund that amount to the Federal Government;

Response: Palmetto does not concur with this recommendation as we believe that the appropriate actions have already been taken. The outlier reconciliation tests were performed after the desk reviews were completed and all adjustments had been determined. Palmetto referred all six (6) of the cost reports to CMS for approval to

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complete the outlier reconciliation. Palmetto received approval from CMS and has completed the outlier reconciliation for one of the cost reports [REDACT] (9/30/07). Palmetto is still awaiting CMS approval to perform the outlier reconciliation on the remaining five (5) reports. Upon approval, the reconciliation process will be completed and a final determination of recoupment will be made. The recoupment of the funds identified will then be completed upon settlement of the respective cost reports.

- review the 2 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not, determine whether these cost reports can be reopened, and work with CMS to resolve \$1,641,927 in funds and associated interest from health care providers that may be due to the Federal Government;

Response: Palmetto does not concur with the recommendation for the cost report for provider [REDACT] FYE 5/31/04. The FI/MAC responsible for this cost report is [REDACT]. Palmetto does not have access to claims data or the cost report for [REDACT] or FYE 5/31/04 and, therefore, cannot reconcile the outlier payments. [REDACT] is responsible for the review of outlier payments for this cost report, we recommend the OIG work with [REDACT] to determine whether the outlier reconciliation process for this cost report has been completed.

Response: Palmetto does not concur with the recommendation for the cost report for provider [REDACT] FYE 9/30/06 since the 3-year reopening deadline had already passed prior to Palmetto receiving the file as part of the J11 MAC transition. Except in cases of fraud, cost reports cannot be reopened beyond three (3) years after the date of settlement of the cost report. Since the outlier reconciliation is not a fraud issue, the cost report cannot be reopened.

- review the 14 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
 - reconcile the \$29,033,914 in associated outlier payments due to the Federal Government (13 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare, and

Response: Palmetto does not concur with the recommendation. CMS has not approved the reconciliation of outlier payments on one (1) of the cost reports. Palmetto completed the outlier reconciliation on the remaining twelve (12) cost reports at the appropriate time. Seven (7) of the 12 cost reports have been finalized. Finalization of three (3) of the 12 cost reports is on hold pending release of the FFY 2004 and FFY 2005 SSI percentages. Finalization of two (2) of the 12 cost reports is on hold pending CMS response to the provider's appeal challenging the application of the time value of money. Of the 7 cost reports that have been settled, \$21,488,697 has been submitted for recoupment through the NPR process. Upon approval from CMS for settlement of the other 5 cost reports, recoupment activities will begin on the remaining amounts identified in the report.

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- reconcile the \$386,996 in associated outlier payments due from Medicare to a provider (1 cost report), finalize that cost report, and return the funds to the provider;

Response: Palmetto does not concur with the recommendation as we believe that the appropriate actions have already been taken at the appropriate time. Palmetto completed the outlier reconciliation on the cost report (REDACTED 9/30/05) on December 13, 2011. Finalization of the cost report is on hold pending release of the FFY 2005 SSI%. Recoupment of the amount identified in the report will occur upon settlement of that cost report.

- work with CMS to resolve the \$1,114,473 in outlier payments associated with the 146 claims that we could not recalculate

Response: Palmetto does not concur with the recommendation. The reconciliation of all but two (2) claims has been completed. Reconciliation of the remaining 2 claims will be completed once CMS approval to complete the outlier reconciliation is received. The recoupment of the amount identified above will be completed upon settlement of the remaining cost report.

- strengthen control procedures to ensure that all cost reports whose outlier payments qualify for reconciliation are correctly identified, referred, and, if necessary, are reopened before the 3-year reopening limit;
- strengthen control procedures to ensure that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

Response: Palmetto does not concur with these final three recommendations. As evidenced in the responses to the OIG findings, Palmetto already has adequate control procedures in place to ensure that all cost reports whose outlier payments require reconciliation are correctly identified, referred to CMS, and reconciled after receiving approval from CMS.

PALMETTO SUMMARY RESPONSE

Palmetto disagrees with the assessment that we did not always refer Medicare cost reports and reconcile outlier payments as required in Jurisdiction 11. The reports identified in the OIG findings as not being properly referred to CMS were the responsibility of the contactor prior to the start of the J11 MAC contract, or the responsibility of [REDACTED]. The reconciliations Palmetto performed were completed within the timeframes established by CMS. As well, Palmetto has adequate control procedures in place to ensure that all cost reports whose outlier payments require reconciliation are correctly identified, referred to CMS, and reconciled after receiving approval from CMS.