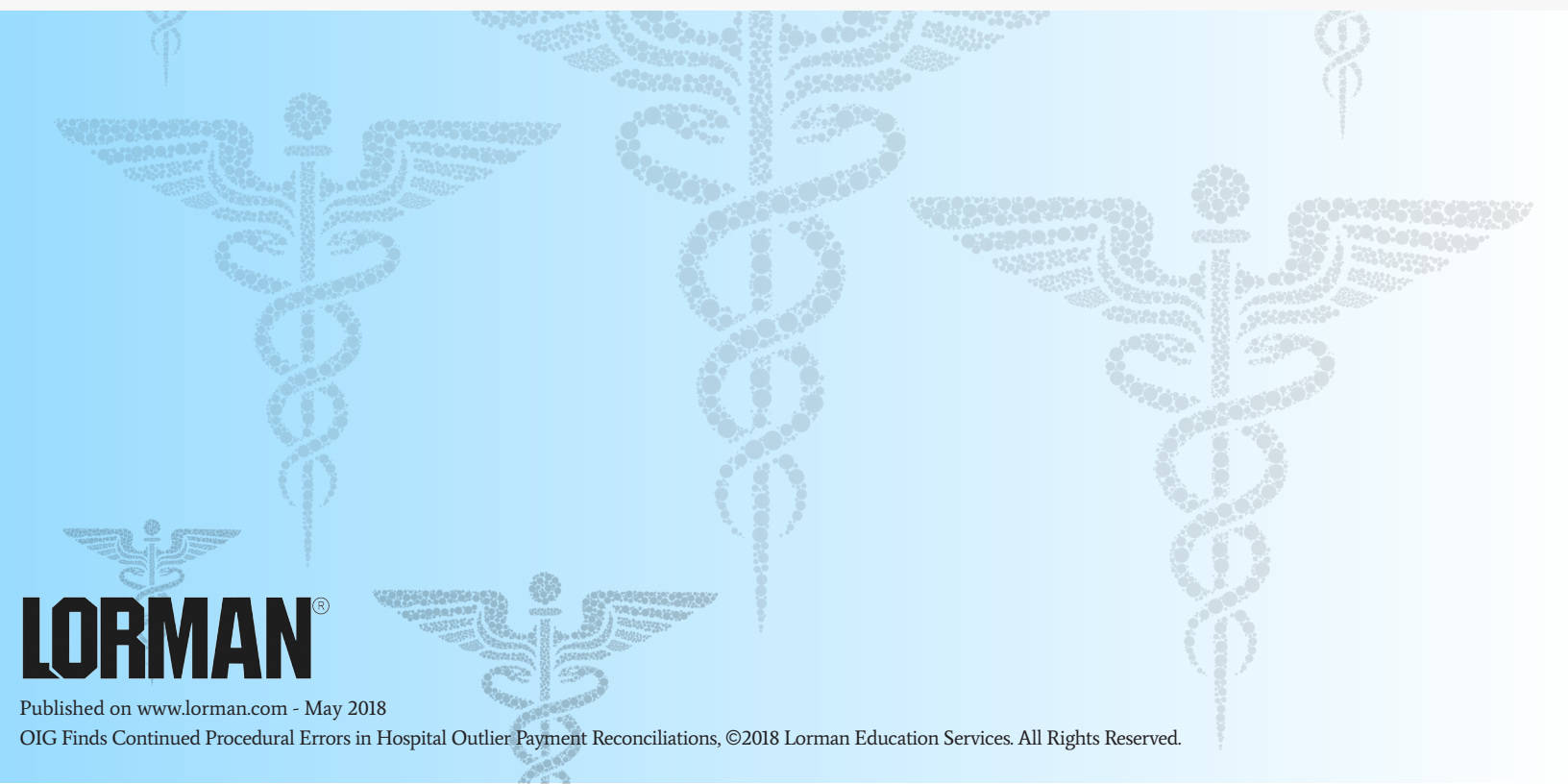




OIG Finds Continued Procedural Errors in Hospital Outlier Payment Reconciliations

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OIG Finds Continued Procedural Errors in Hospital Outlier Payment Reconciliations

Written by Leslie Demaree Goldsmith – 10/12/17

The U.S. Department of Health and Human Services, Office of Inspector General (OIG) recently released a report concluding that there are vulnerabilities in the process of reconciling Medicare hospital outlier payments. The report summarizes the results of a previous 2012 OIG audit of outlier reconciliations, in which the OIG reviewed outlier payment data submitted to CMS by a sample of Medicare contractors during the audit period of October 1, 2003 through December 31, 2008, and a series of subsequent reviews of outlier payments. The OIG looked into whether (1) "Medicare contractors had referred qualified cost reports to CMS for reconciliation in accordance with Federal guidelines" and (2) "outlier payments associated with qualifying cost reports had been reconciled." As discussed in more detail below, the OIG indicated that there are still vulnerabilities in Medicare hospital outlier payments – within CMS and by the Medicare contractors – and issued recommendations to remedy the vulnerabilities.

Background

CMS uses a prospective payment system (PPS) to pay hospitals for providing inpatient hospital services to Medicare beneficiaries. Since payment for inpatient services is provided on a prospective basis, Medicare provides for supplemental payments to Medicare-participating hospitals, in addition to the basic prospective payments, to account for cases incurring substantially high costs that surpass a specific threshold amount (i.e., outlier payments). Medicare contractors are tasked, in part, with processing and paying the Medicare claims, which includes calculating outlier payments based on the hospitals' claim submissions and by using a hospital-specific cost-to-charge ratio (CCR).

In calendar year (CY) 2003, CMS implemented regulations and guidance requiring Medicare contractors to refer the hospitals' cost reports to CMS to re-price submitted claims before settling hospital cost reports. This process was to ensure that the payments reflected actual costs that each Medicare-participating hospital incurred. According to CMS policy, cost reports were to be referred to CMS if the reconciliation threshold was met. Such threshold was based on the ratio of costs to charges and the outlier payments reflected in a hospital's cost report. Due to system limitations, CMS directed Medicare contractors to perform the reconciliations, effective April 1, 2011, both in backlog and on a going forward basis, upon authorization from the CMS Central Office.

OIG Findings

In its previous audits, the OIG found that for the period of October 2003 through March 2011 (when CMS was tasked with reconciliations):

- Medicare contractors did not always refer costs reports to CMS that qualified for reconciliation and
- CMS did not always ensure that Medicare contractors reconciled the outlier payments associated with cost reports that had been referred.

Additionally, the OIG noted that its previous reviews indicated that 465 cost reports qualified for reconciliation of outlier payments. As of December 31, 2011, however:

- 110 had not been referred for reconciliation, resulting in \$155,826,145 due to Medicare and \$11,509,084 due to hospitals;
- 287 had been referred to CMS, but 153 of the 287 had not had their outlier payments reconciled, resulting in \$298,878,787 due to Medicare and \$17,301,432 due to hospitals;
- the remaining 68 qualified for reconciliation but may have had inaccurate cost report data, resulting in \$144,905,579 in associated outlier payments but the OIG could not determine the exact financial impact; and

- of the 110 cost reports that were not referred for reconciliation, 59 had been settled and exceeded the three-year reopening limit. Additionally, of the 153 cost reports referred for reconciliation but were not reconciled, five had been settled and exceeded the three-year reopening limit.

Finally, the OIG determined that CMS did not:

- maintain a complete listing of the cost reports that Medicare contractors referred for reconciliation and
- always ensure that the Medicare contractors correctly identified cost reports that qualified for reconciliation, referred all qualifying cost reports to CMS for reconciliation, and reconciled the associated outlier payments.

OIG's Recommendations to CMS

Based on its findings, the OIG recommended that CMS:

1. ensure the Medicare contractors are continuing to take the corrective actions that the OIG previously recommended, including collecting overpayments and returning those funds to either Medicare or hospitals;
2. determine whether any of the cost reports that exceeded the three-year reopening limit may be

reopened due to the hospitals' fault or fraud and, if so, to work with the Medicare contractors to reopen them;

3. ensure that the Medicare contractors review all cost reports submitted since the end of the OIG's previous audit periods and ensure that those whose outlier payments qualified for reconciliation are correctly identified, referred, and reconciled in accordance with Federal guidelines; and
4. maintain a system that identifies and tracks all cost reports that Medicare contractors have referred for reconciliation and a system that recalculates outlier payments on the basis of claim submissions made by hospitals.

Baker Donelson Comments

Hospitals should be aware that the OIG has recommended that CMS reopen the 64 settled cost reports that have exceeded the three-year reopening limit, reasoning that:

Because the outlier reconciliation rules are promulgated in the Federal regulations and CMS guidance, providers knew or should have known the rules when their cost reports were settled. CMS regulations and guidance permit the reopening of cost reports (by Medicare contractors) beyond the three years for fraud or similar fault. We believe that these regulations and guidance. . . apply to these 59

unreferred [and five referred, but not reconciled] cost reports.

The OIG is asserting the exception to the three-year reopening rule as a means for the Medicare program to collect \$76,738,002 in outlier payments that the OIG now finds were improper, and perhaps to pay \$17,594,091 in outlier payments due to providers. CMS responded to this recommendation by stating that it would explore if there is more conclusive evidence of similar fault to support such a reopening. The rule permits reopenings beyond the three-year period only when the decision being reopened "was procured by fraud or similar fault." 42 C.F.R. § 405.1885(b)(3). Providers may have a good basis to assert that reopenings in this situation would be inappropriate, because the outlier determinations by Medicare were not procured through any fraud or similar fault of the providers, as all necessary action to process the reconciliations fell exclusively with the Medicare program.

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