Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORIDIAN HEALTHCARE SOLUTIONS, LLC, CLAIMED UNALLOWABLE MEDICARE NONQUALIFIED RESTORATION SAVINGS PLAN COSTS THROUGH ITS INCURRED COST PROPOSALS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Amy J. Frontz
Deputy Inspector General
for Audit Services

April 2021
A-07-20-00591

Office of Inspector General

https://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at https://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: April 2021
Report No. A-07-20-00591

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Noridian Healthcare Solutions, LLC, Claimed Unallowable Medicare Nonqualified Restoration Savings Plan Costs Through Its Incurred Cost Proposals

Why OIG Did This Audit

The Centers for Medicare & Medicaid Services (CMS) reimburses a portion of its contractors' nonqualified plan (nonqualified) costs.

At CMS's request, the HHS, OIG, Office of Audit Services, Region VII pension audit team reviews the cost elements related to nonqualified plans and any other pension-related cost elements claimed by Medicare contractors through Incurred Cost Proposals (ICPs).

Previous OIG audits found that Medicare contractors did not always comply with Federal requirements when claiming nonqualified costs for Medicare reimbursement.

Our objective was to determine whether the calendar years (CYs) 2015 and 2016 nonqualified Restoration Savings Plan (restoration) costs that Noridian Healthcare Solutions, LLC (NHS), claimed for Medicare reimbursement, and reported on its ICPs, were allowable and correctly claimed.

How OIG Did This Audit

We reviewed $164,839 of restoration costs that NHS claimed for Medicare reimbursement on its ICPs for CYs 2015 and 2016.

What OIG Found

NHS claimed CYs 2015 and 2016 restoration costs of $164,839 for Medicare reimbursement; however, we determined that the allowable restoration costs during this period were $4,524. The difference, $160,315, represented unallowable Medicare restoration costs that NHS claimed on its ICPs for CYs 2015 and 2016. NHS claimed these unallowable Medicare restoration costs primarily because it did not calculate these costs in accordance with Federal regulations and the Medicare contracts' requirements.

What OIG Recommends and Auditee Comments

We recommend that NHS work with CMS to ensure that its final settlement of contract costs reflects a decrease in Medicare restoration costs of $160,315 for CYs 2015 and 2016.

NHS concurred with our recommendation. NHS stated that it would work with CMS to ensure that its final settlement of contract costs reflects a decrease in Medicare restoration costs of $160,315 for CYs 2015 and 2016.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) reimburses a portion of its contractors' nonqualified plan (nonqualified) costs. In claiming nonqualified costs, contractors must follow cost reimbursement principles contained in the Federal Acquisition Regulation (FAR), the Cost Accounting Standards (CAS), and the Medicare contracts. Previous Office of Inspector General (OIG) audits found that Medicare contractors did not always comply with Federal requirements when claiming nonqualified costs for Medicare reimbursement.

At CMS's request, the OIG, Office of Audit Services, Region VII pension audit team reviews the cost elements related to qualified defined-benefit, nonqualified defined-benefit, postretirement benefit, and any other pension-related cost elements claimed by Medicare fiscal intermediaries and carrier contractors and Medicare administrative contractors (MACs) through Final Administrative Cost Proposals, Incurred Cost Proposals (ICPs), or both.

For this audit, we focused on one Medicare contractor, Noridian Healthcare Solutions, LLC (NHS). In particular, we examined the nonqualified Restoration Savings Plan (restoration) costs that NHS claimed for Medicare reimbursement, under the provisions of its MAC contracts and CAS- and FAR-covered contracts, and reported on its ICPs.

OBJECTIVE

Our objective was to determine whether the calendar years (CYs) 2015 and 2016 restoration costs that NHS claimed for Medicare reimbursement, and reported on its ICPs, were allowable and correctly claimed.

BACKGROUND

Noridian Healthcare Solutions, LLC, and Medicare

NHS is a subsidiary of Blue Cross Blue Shield of North Dakota (BCBS North Dakota) (formerly Noridian Mutual Insurance Company), whose home office is in Fargo, North Dakota. NHS administered Medicare Part A, Medicare Part B, and Medicare Durable Medical Equipment (DME) contract operations under MAC contracts for Medicare Parts A and B Jurisdictions E[1] and

[1] Medicare Parts A and B Jurisdiction E includes the States of California, Hawaii, and Nevada, and the U.S. Territories of American Samoa, Guam, and the Northern Mariana Islands.

F[2] and Medicare DME Jurisdictions A[3] and D.[4] In addition, NHS held the Pricing, Data Analysis and Coding (PDAC) contract.

Restoration Plan

Both BCBS North Dakota and NHS sponsor nonqualified plans called the Noridian Mutual Insurance Company Restoration Savings Plan and Noridian Healthcare Solutions, LLC, Restoration Savings Plan. The purpose of these plans is to provide deferred compensation for a select group of management or highly compensated employees within the meaning of the Employee Retirement Income Security Act of 1974. NHS claimed nonqualified costs using the pay-as-you-go basis of accounting.

This report addresses the allowable restoration costs claimed by NHS under the provisions of its MAC contracts and CAS- and FAR-covered contracts.

The disclosure statement that NHS submits to CMS states that NHS uses pooled cost accounting. Medicare contractors use pooled cost accounting to calculate the indirect cost rates (whose computations include pension, postretirement benefit, Supplemental Executive Retirement Plan, and Restoration Plan costs) that they submit on their ICPs. Medicare contractors use the indirect cost rates to calculate the contract costs that they report on their ICPs. In turn, CMS uses these indirect cost rates in determining the final indirect cost rates for each contract.[5]

Accounting Methodologies

The Medicare contracts require NHS to calculate nonqualified costs in accordance with the FAR and CAS 412 and 413. The FAR and the CAS require that the costs for nonqualified plans be measured under either the accrual method or the pay-as-you-go method. Under the accrual method, allowable costs are based on the annual contributions that the employer deposits into its trust fund. For nonqualified plans that are not funded through the use of a funding agency, costs are to be accounted for under the pay-as-you-go method. This method is based on the

[2] Medicare Parts A and B Jurisdiction F includes the States of Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

[3] Medicare DME Jurisdiction A includes the States of Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont, and the District of Columbia.

[4] Medicare DME Jurisdiction D includes the States of Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming, and the U.S. Territories of American Samoa, Guam, and the Northern Mariana Islands.

[5] For each CY, each Medicare contractor submits to CMS an ICP that reports the Medicare direct and indirect costs that the contractor incurred during that year. The ICP and supporting data provide the basis for the CMS Contracting Officer and the Medicare contractor to determine the final billing rates for allowable Medicare costs.

actual benefits paid to participants, which are comprised of lump-sum payments and annuity payments.

Incurred Cost Proposal Audit

At CMS's request, Kearney and Company (Kearney) performed an audit of the ICPs that NHS submitted for CYs 2015 and 2016. The objectives of the Kearney audit were to determine whether costs were allowable in accordance with the FAR, the Department of Health and Human Services Acquisition Regulation, and the CAS.

For our current audit, we relied on the Kearney audit findings and recommendations when computing the allowable restoration costs discussed in this report.

We incorporated the results of the Kearney audit into our computations of the audited indirect cost rates, and ultimately the restoration costs claimed, for the contracts subject to the FAR. CMS will use our report on allowable restoration costs, as well as the Kearney audit report, to determine the final indirect cost rates and the total allowable contract costs for NHS for CYs 2015 and 2016. The cognizant Contracting Officer will perform a final settlement with the contractor to determine the final indirect cost rates. These rates ultimately determine the final costs of each contract.[6]

HOW WE CONDUCTED THIS AUDIT

We reviewed $164,839 of restoration costs that NHS claimed for Medicare reimbursement on its ICPs for CYs 2015 and 2016.

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 finding and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology.

FINDING

NHS claimed CYs 2015 and 2016 restoration costs of $164,839 for Medicare reimbursement; however, we determined that the allowable restoration costs during this period were $4,524. The difference, $160,315, represented unallowable Medicare restoration costs that NHS

[6] In accordance with FAR 42.705-1(b)(5)(ii) and FAR 42.705-1(b)(5)(iii)(B), the cognizant Contracting Officer shall "[p]repare a written indirect cost rate agreement conforming to the requirements of the contracts" and perform a "[r]econciliation of all costs questioned, with identification of items and amounts allowed or disallowed in the final settlement," respectively.

claimed on its ICPs for CYs 2015 and 2016. NHS claimed these unallowable Medicare restoration costs primarily because it did not calculate these costs in accordance with Federal regulations and the Medicare contracts' requirements.

The Medicare contracts require that nonqualified costs be calculated in accordance with the FAR and the CAS. NHS did not calculate its restoration costs in accordance with the FAR or the CAS. In fact, NHS elected to compute the allowable restoration costs by using a percentage of each plan participant's salary. However, we determined that the restoration plans did not offer a benefit that is payable for life; therefore, the plans did not qualify as a "pension plan" as defined in FAR 31.001. Thus, NHS did not claim costs in accordance with the appropriate Federal regulations. NHS should have identified the restoration costs in accordance with the regulations for a deferred compensation plan and should have calculated those costs in accordance with the FAR and CAS 415.

Because NHS's plan did not qualify as a pension plan, we calculated its plan costs in accordance with FAR 31.205-6(k) and CAS 415, which govern deferred compensation plans. Specifically, we calculated the allowable restoration costs based on actual payments to restoration plan participants in accordance with CAS 415.40(a). On this basis, we determined the allowable restoration costs for CYs 2015 and 2016. (Our calculation does not appear in this report because the indirect cost rate computations that NHS used in its ICPs, and to which we referred as part of our audit, are proprietary information.) For details on the Federal requirements, see Appendix B.

ALLOCABLE MEDICARE SEGMENT RESTORATION PLAN COSTS OVERSTATED

During this audit, we calculated the allocable Medicare segment restoration costs for CYs 2015 and 2016 in accordance with Federal requirements.[7] We determined that the allocable Medicare segment restoration costs for CYs 2015 and 2016 totaled $0. NHS reported that its allocable restoration costs totaled $138,367. Therefore, NHS overstated the allocable Medicare segment restoration costs by $138,367. This overstatement occurred because of differences in the accounting methodology used to calculate the restoration costs for Medicare reimbursement (as discussed above in "Finding").

Table 1 on the following page shows the differences between the allocable Medicare segment restoration costs that we determined for CYs 2015 and 2016 and the restoration costs that NHS calculated for the same time period.

[7] For the current audit, we incorporated these allocable restoration costs into the indirect cost rates to determine the allowable restoration costs.

Table 1: Allocable Medicare Segment Restoration Costs

CY	Allocable Per Audit	Per NHS	Difference
2015	$0	$70,537	($70,537)
2016	0	67,830	(67,830)
Total	**$0**	**$138,367**	**($138,367)**

ALLOCABLE OTHER SEGMENT RESTORATION PLAN COSTS OVERSTATED

During the current audit, we calculated the allocable Other segment restoration costs for CYs 2015 and 2016 in accordance with Federal requirements. We determined that the allocable Other segment restoration costs for CYs 2015 and 2016 totaled $18,134. NHS reported that its allocable restoration costs totaled $116,721. Therefore, NHS overstated the allocable Other segment restoration costs by $98,587. This overstatement occurred because of differences in the accounting methodology used to calculate the restoration costs for Medicare reimbursement (as discussed above in "Finding").

Table 2 below shows the allocable Other segment restoration costs that we determined for CYs 2015 and 2016.

Table 2: Allocable Other Segment Restoration Costs

CY	Allocable Per Audit	Per NHS	Difference
2015	$0	$56,821	($56,821)
2016	18,134	59,900	(41,766)
Total	**$18,134**	**$116,721**	**($98,587)**

We used the allocable restoration plan costs to adjust the indirect cost rates (i.e., the fringe benefit and general and administrative rates) and, in turn, to calculate the information presented in Table 3 later in this report. (Our calculation does not appear in this report because those rate computations that NHS used in its ICPs, and to which we referred as part of our audit, are proprietary information.)

RESTORATION PLAN COSTS CLAIMED

NHS claimed Medicare restoration costs of $164,839 on its ICPs for CYs 2015 and 2016. We calculated the allowable Medicare restoration costs in accordance with the FAR and the CAS. For details on the Federal requirements, see Appendix B.

UNALLOWABLE RESTORATION PLAN COSTS CLAIMED

After incorporating the results of the Kearney audit and our adjustments to the indirect cost rates, we determined that the allowable restoration costs for CYs 2015 and 2016 were $4,524. Thus, NHS claimed $160,315 (that is, $164,839 minus $4,524) of unallowable Medicare restoration costs on its ICPs for CYs 2015 and 2016. This overclaim occurred primarily because NHS based its claim for Medicare reimbursement on an incorrect cost accounting method when calculating its restoration costs for Medicare reimbursement (as discussed above in "Finding").

Table 3 below compares the Medicare restoration costs that we calculated (using our adjusted indirect cost rates) to the restoration costs that NHS claimed for Medicare reimbursement for CYs 2015 and 2016.

Table 3: Comparison of Allowable Restoration Costs and Claimed Restoration Costs

CY	Allowable Per Audit	Per NHS	Difference
2015	$0	$84,211	($84,211)
2016	4,524	80,628	(76,104)
Total	**$4,524**	**$164,839**	**($160,315)**

RECOMMENDATION

We recommend that Noridian Healthcare Solutions, LLC, work with CMS to ensure that its final settlement of contract costs reflects a decrease in Medicare restoration costs of $160,315 for CYs 2015 and 2016.[8]

AUDITEE COMMENTS

In written comments on our draft report, NHS concurred with our recommendation. NHS stated that it would work with CMS to ensure that its final settlement of contract costs reflects a decrease in Medicare restoration costs of $160,315 for CYs 2015 and 2016.

NHS's comments are included in their entirety as Appendix C.

[8] The finding and recommendation reflect changes that we made in conjunction with NHS's review of the draft report. NHS agreed with the updated finding and recommendation and responded accordingly. We maintain that our finding and recommendation, as revised, are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed $164,839 of restoration costs that NHS claimed for Medicare reimbursement on its ICPs for CYs 2015 and 2016.

Achieving our objective did not require that we review NHS's overall internal control structure. We reviewed the internal controls related to the restoration costs claimed for Medicare reimbursement to ensure that those costs were allocable in accordance with the CAS and allowable in accordance with the FAR.

We performed fieldwork at our office in Jefferson City, Missouri.

METHODOLOGY

To accomplish our objective, we:

- reviewed the portions of the FAR, CAS, and Medicare contracts applicable to this audit;
- reviewed the Noridian Mutual Insurance Company Restoration Savings Plan and Noridian Healthcare Solutions, LLC, Restoration Savings Plan documents;
- reviewed accounting records and ICP information provided by NHS to identify the amount of restoration costs claimed for Medicare reimbursement for CYs 2015 and 2016;
- reviewed the results of the Kearney audit and incorporated those results into our calculations of allowable restoration costs;
- calculated allowable restoration costs in accordance with applicable provisions of the FAR and CAS; and
- provided the results of our audit to NHS officials on December 8, 2020.

We performed this audit in conjunction with the following audit and used the information obtained during it: *Noridian Healthcare Solutions, LLC, Claimed Some Unallowable Medicare Nonqualified Plan Costs Through Its Incurred Cost Proposals* (A-07-20-00590, September 16, 2020).

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 finding and conclusions based on our audit objectives.

APPENDIX B: FEDERAL REQUIREMENTS RELATED TO REIMBURSEMENT OF NONQUALIFIED PLAN COSTS

FEDERAL REGULATIONS

FAR 31.001 defines a "pension plan" as follows:

> 'Pension plan' means a deferred compensation plan established and maintained by one or more employers to provide systematically for the payment of benefits to plan participants after their retirements, provided that the benefits are paid for life or are payable for life at the option of the employees. Additional benefits such as permanent and total disability and death payments, and survivorship payments to beneficiaries of deceased employees, may be an integral part of a pension plan.

FAR 31.001 also defines "deferred compensation" as follows:

> 'Deferred compensation' means an award made by an employer to compensate an employee in a future cost accounting period or periods for services rendered in one or more cost accounting periods before the date of the receipt of compensation by the employee. This definition shall not include the amount of year end accruals for salaries, wages, or bonuses that are to be paid within a reasonable period of time after the end of a cost accounting period.

The allowability of costs for deferred compensation plans is governed by FAR 31.205-6. FAR 31.205-6(k) states that costs shall be measured, assigned, and allocated in accordance with CAS 415.

Federal regulations (FAR 52.216-7(a)(1)) address the invoicing requirements and the allowability of payments as determined by the Contracting Officer in accordance with FAR subpart 31.2.

Federal regulations (CAS 415.40(a)) state that the cost of deferred compensation shall be assigned to the cost accounting period in which the contractor incurs an obligation to compensate the employee. In the event no obligation is incurred prior to payment, the cost shall be assigned to the cost accounting period in which the payment is made.

Federal regulations (CAS 415.50(a)) state that the contractor shall be deemed to have incurred an obligation for the cost of deferred compensation when all of the following conditions have been met:

(1) There is a requirement to make the future payment(s) which the contractor cannot unilaterally avoid.

(2) The deferred compensation award is to be satisfied by a future payment of money, other assets, or shares of stock of the contractor.

(3) The amount of the future payment can be measured with reasonable accuracy.

(4) The recipient of the award is known.

(5) If the terms of the award require that certain events must occur before an employee is entitled to receive the benefits, there is a reasonable probability that the options ultimately will occur.

Federal regulations (CAS 415.50(b)) states that if any of the conditions in CAS 415-50(a) is not met, the cost of deferred compensation shall be assignable only to the cost accounting period or periods in which the compensation is paid to the employee.

MEDICARE CONTRACTS

The Medicare contracts require NHS to submit invoices in accordance with FAR 52.216-7, "Allowable Cost & Payment." (See our citation to FAR 52.216-7(a)(1) in "Federal Regulations" above.)

APPENDIX C: AUDITEE COMMENTS

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, ND 58121

March 4, 2021

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

Report Number: A-07-20-00591

Report Title: Noridian Healthcare Solutions, LLC, Claimed Unallowable Medicare Nonqualified Restoration Savings Plan Costs Through Its Incurred Cost Proposal

Recommendation – From Report

We recommend that Noridian Healthcare Solutions, LLC, work with CMS to ensure that its final settlement of contract costs reflects a decrease in Medicare restoration costs of $160,315 for CYs 2015 and 2016.

Statement of concurrence or non-concurrence:

Noridian Healthcare Solutions, LLC concurs with the above recommendation.

- For a concurrence, please include a statement describing the nature of the corrective action taken or planned.
- For a nonconcurrence, please include specific reasons for the nonconcurrence and a statement of any alternative corrective action taken or planned.

Noridian will work with CMS to ensure that its final settlement of contract costs reflects a decrease in Medicare restoration costs of $160,315 for CYs 2015 and 2016.

Signed: ____/David Breuer/_____ Date: _____3-4-21_____
David Breuer, Executive Vice President and Chief Financial Officer
Blue Cross Blue Shield of North Dakota