



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 15 2006

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Review of TriSpan Health Services's Payments to Community Mental Health Centers for Partial Hospitalization Services for the Period August 1, 2000, Through June 30, 2003 (A-06-04-00065)

Attached is an advance copy of our final report on TriSpan Health Services's (TriSpan) payments to community mental health centers (CMHC) for partial hospitalization services for the period August 1, 2000, through June 30, 2003. We will issue this report to TriSpan, a fiscal intermediary, within 5 business days. This is one of a series of reports on Medicare partial hospitalization services provided by CMHCs.

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care. Under the Medicare hospital outpatient prospective payment system, which was implemented in August 2000, CMHCs receive per diem payments for partial hospitalization services. Medicare may make additional payments, called outlier payments, if the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses.

Our objective was to determine whether TriSpan calculated Medicare outlier and per diem payments to CMHCs in accordance with Medicare reimbursement requirements.

TriSpan did not always calculate Medicare outlier and per diem payments to CMHCs in accordance with Medicare reimbursement requirements. In calculating outlier payments, TriSpan:

- used incorrect cost report information to compute some cost-to-charge ratios,
- incorrectly entered one cost-to-charge ratio in the outpatient provider-specific file within the claim-processing system, and
- improperly updated some cost-to-charge ratios.

In calculating per diem payments, TriSpan assigned the wrong geographic wage index factor to certain CMHCs.

These errors occurred because of weaknesses in TriSpan's internal controls. Because TriSpan used incorrect cost-to-charge ratios and wage index factors, it overpaid CMHCs \$7,958,659. (We identified a total overpayment of \$16.2 million, of which \$8.2 million was covered in report number A-06-04-00032 on a specific CMHC.)

We recommend that TriSpan:

- recover \$7,958,659 in improper outlier and per diem payments for services rendered between August 1, 2000, and June 30, 2003;
- review claims with dates of service subsequent to our audit period to ensure that they were paid in accordance with Medicare reimbursement requirements and make any necessary financial adjustments; and
- implement internal controls to ensure that future outlier and per diem payments are calculated with the correct cost-to-charge ratio, effective date, and wage index factor.

In its comments on our draft report, TriSpan disagreed in part that it made errors when it initially established CMHC payments. TriSpan also disagreed with the causes that we identified and with our first and last recommendations. However, TriSpan agreed that it had assigned the wrong geographic wage index factor and that it had not updated cost-to-charge ratios in accordance with Centers for Medicare & Medicaid Services guidance. TriSpan did not fully address the second recommendation to review all claims subsequent to our audit period because TriSpan stated that it was limited to reviewing and adjusting the claims available on the system.

TriSpan's comments did not provide any additional information that would lead us to change the findings, causes, or recommendations included in the draft report.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414 or through e-mail at Gordon.Sato@oig.hhs.gov. Please refer to report number A-06-04-00065.

Attachment



SEP 18 2006

Office of Audit Services
1100 Commerce, Room 686
Dallas, TX 75242

Report Number: A-06-04-00065

Mr. William V. Morris III
Vice President, Government Programs
TriSpan Health Services
Medicare Part A Intermediary
1064 Flynt Drive
Flowood, Mississippi 39232-9570

Dear Mr. Morris:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of TriSpan Health Services's Payments to Community Mental Health Centers for Partial Hospitalization Services for the Period August 1, 2000, Through June 30, 2003." A copy of this report will be forwarded to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-06-04-00065 in all correspondence.

Sincerely yours,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Roger Perez
Regional Administrator (Acting)
Centers for Medicare & Medicaid Services, Region IV
Atlanta Federal Center
61 Forsyth Street SW., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF TRISPAN HEALTH
SERVICES'S PAYMENTS TO
COMMUNITY MENTAL HEALTH
CENTERS FOR PARTIAL
HOSPITALIZATION SERVICES
FOR THE PERIOD
AUGUST 1, 2000, THROUGH
JUNE 30, 2003**



Daniel R. Levinson
Inspector General

September 2006
A-06-04-00065

Office of Inspector General

<http://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 all 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 assessments 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. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, 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 in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

BACKGROUND

Partial hospitalization is an intensive outpatient program of psychiatric services that community mental health centers (CMHC) or hospitals may provide to patients in lieu of inpatient psychiatric care. Under the Medicare hospital outpatient prospective payment system, which was implemented in August 2000, providers receive per diem payments for partial hospitalization services. Medicare may make additional payments, called outlier payments, if the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses.

In calendar year 2001, CMHCs nationwide received approximately \$48 million in outlier payments for partial hospitalization services, whereas hospitals received only \$9,000. Of the Nation's 125 CMHCs, 20 received approximately two-thirds of all outlier payments made to partial hospitalization providers.

We conducted this audit because the Centers for Medicare & Medicaid Services (CMS) raised concerns about excessive Medicare outlier payments to CMHCs. This review is part of a series of audits of payments to CMHCs.

OBJECTIVE

Our objective was to determine whether a fiscal intermediary, TriSpan Health Services (TriSpan), calculated Medicare outlier and per diem payments to CMHCs in accordance with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

TriSpan did not always calculate Medicare outlier and per diem payments to CMHCs in accordance with Medicare reimbursement requirements. In calculating outlier payments, TriSpan:

- used incorrect cost report information to compute some cost-to-charge ratios,
- incorrectly entered one cost-to-charge ratio in the outpatient provider-specific file within the claim-processing system, and
- improperly updated some cost-to-charge ratios.

In calculating per diem payments, TriSpan assigned the wrong geographic wage index factor to certain CMHCs.

These errors occurred because of weaknesses in TriSpan's internal controls. Because TriSpan used incorrect cost-to-charge ratios and wage index factors, it overpaid CMHCs \$7,958,659 for services between August 1, 2000, and June 30, 2003.¹

RECOMMENDATIONS

We recommend that TriSpan:

- recover \$7,958,659 in improper outlier and per diem payments for services rendered between August 1, 2000, and June 30, 2003;
- review claims with dates of service subsequent to our audit period to ensure that they were paid in accordance with Medicare reimbursement requirements and make any necessary financial adjustments; and
- implement internal controls to ensure that future outlier and per diem payments are calculated with the correct cost-to-charge ratio, effective date, and wage index factor.

TRISPAN COMMENTS

In its comments on our draft report, TriSpan disagreed in part that it made errors when it initially established CMHC payments. TriSpan also disagreed with the causes that we identified and with our first and last recommendations. However, TriSpan agreed that it had assigned the wrong geographic wage index factor and that it had not updated cost-to-charge ratios in accordance with CMS guidance. TriSpan did not fully address the second recommendation to review all claims subsequent to our audit period because TriSpan stated that it was limited to reviewing and adjusting the claims available on the system.

TriSpan's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

TriSpan's comments did not provide any additional information that would lead us to change the findings, causes, or recommendations included in the draft report.

¹We identified a total overpayment of \$16.2 million. Because we covered \$8.2 million of the total in another report (A-06-04-00032) on a specific CMHC, this report discusses overpayments for all other CMHCs in TriSpan's service area.

TABLE OF CONTENTS

| | <u>Page</u> |
|--------------------------------------------------------------------------------------------------------|-------------|
| INTRODUCTION | 1 |
| BACKGROUND | 1 |
| Partial Hospitalization Program..... | 1 |
| Cost-to-Charge Ratios..... | 1 |
| Intermediary Responsibilities | 2 |
| Tentative and Final Settlements of Medicare Cost Reports..... | 2 |
| Steps To Address High Outlier Payments | 2 |
| TriSpan Health Services | 2 |
| OBJECTIVE, SCOPE, AND METHODOLOGY | 3 |
| Objective..... | 3 |
| Scope..... | 3 |
| Methodology..... | 3 |
| FINDINGS AND RECOMMENDATIONS | 4 |
| FEDERAL REQUIREMENTS | 4 |
| Establishing Cost-to-Charge Ratios..... | 4 |
| Adjusting Payments To Reflect Geographic Wage Variations..... | 5 |
| Updating Cost-to-Charge Ratios..... | 5 |
| Authority To Retroactively Adjust Outlier Payments | 5 |
| IMPROPER CALCULATION OF OUTLIER PAYMENTS | 6 |
| TriSpan Used Incorrect Cost Report Information To Compute Cost-to-Charge Ratios..... | 6 |
| TriSpan Incorrectly Entered One Cost-to-Charge Ratio in the Outpatient Provider-Specific File | 6 |
| TriSpan Improperly Updated Cost-to-Charge Ratios | 7 |
| IMPROPER CALCULATION OF PER DIEM PAYMENTS | 7 |
| INADEQUATE INTERNAL CONTROLS | 7 |
| OVERPAYMENTS | 8 |
| RECOMMENDATIONS | 8 |
| TRISPAN COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE | 9 |
| Use of Partial-Year Cost Reports..... | 9 |
| Use of Inaccurate Cost Report Figures | 9 |
| Incorrectly Entered Provider-Specific Ratio..... | 10 |

| | |
|-----------------------------------|----|
| Inadequate Internal Controls..... | 10 |
| Recovery of Overpayments..... | 11 |

APPENDIX

TRISPAN COMMENTS

INTRODUCTION

BACKGROUND

We conducted this audit because the Centers for Medicare & Medicaid Services (CMS) raised concerns about excessive Medicare outlier payments to community mental health centers (CMHC). This review is part of a series of audits of payments to CMHCs.

Partial Hospitalization Program

Pursuant to section 1861(ff) of the Social Security Act, partial hospitalization is an intensive outpatient program of psychiatric services that CMHCs or hospitals may provide to individuals in lieu of inpatient psychiatric care. The program is designed to provide individuals who have mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment involving nurses, psychiatrists, psychologists, and social workers.

Pursuant to the Balanced Budget Act of 1997, Medicare pays for partial hospitalization services as part of the hospital outpatient prospective payment system (PPS), which was implemented in August 2000. Under the PPS, Medicare makes per diem payments to partial hospitalization providers. Medicare may make additional payments, called outlier payments, if the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses.

Medicare makes outlier payments when the provider's charges for the services, adjusted to cost, exceed a threshold amount that CMS establishes. Effective August 2000, CMS established the threshold amount at 2.5 times the per diem payment. Effective April 2002, CMS increased the threshold to 3.5 times the per diem payment and decreased it to 2.75 times the per diem payment effective January 2003. A change in the per diem amount will affect the threshold amount and, in turn, the outlier payment.

In calendar year 2001, CMHCs nationwide received approximately \$48 million in outlier payments for partial hospitalization services, whereas hospitals received only \$9,000. Of the Nation's 125 CMHCs, 20 received approximately two-thirds of all outlier payments made to partial hospitalization providers.

Cost-to-Charge Ratios

Medicare claims contain data on patient charges. To determine whether a claim qualifies for an outlier payment, Medicare fiscal intermediaries must convert billed charges to estimated costs using a cost-to-charge ratio. The use of a properly computed, provider-specific cost-to-charge ratio is essential to ensure that Medicare makes outlier payments only for cases that have extraordinarily high costs, not merely high charges. Intermediaries should calculate these ratios by dividing total patient-related costs by total charges as shown on the providers' Medicare cost reports.

Intermediary Responsibilities

CMS contracts with fiscal intermediaries for assistance in administering the partial hospitalization program, including:

- processing and paying claims from CMHCs,
- calculating initial cost-to-charge ratios based on fiscal year (FY) 1997 Medicare cost reports,
- computing outlier payment amounts,
- updating cost-to-charge ratios based on the most recent cost reports available,
- conducting audits of CMHCs' cost reports, and
- reviewing claims for medical necessity and reasonableness of services.

Tentative and Final Settlements of Medicare Cost Reports

Each CMHC is required to file a Medicare cost report each year. After accepting the cost report, the fiscal intermediary performs a tentative settlement to ensure that providers are reimbursed expeditiously. The intermediary may perform a detailed audit after the tentative settlement. If the intermediary does not perform a detailed audit, the intermediary determines final settlement by performing a limited desk audit. After auditing the cost report, the intermediary issues a notice of program reimbursement. As the final settlement document, this notice shows whether payment is owed to the provider or the Medicare program.

Steps To Address High Outlier Payments

In January 2003, to address its concerns about excessive outlier payments to CMHCs, CMS instructed fiscal intermediaries to update cost-to-charge ratios beginning April 30, 2003. The updates are to reflect cost and charge information from more recent cost reports. Each revised cost-to-charge ratio must be entered in the outpatient provider-specific file no later than 30 days after the date of the most recent tentative or final cost report settlement used in calculating the ratio.

TriSpan Health Services

Blue Cross and Blue Shield of Mississippi, doing business as TriSpan Health Services (TriSpan), is a CMS-contracted Part A fiscal intermediary located in Jackson, Mississippi. TriSpan's Part A provider service area includes Louisiana, Mississippi, and Missouri.

TriSpan paid the 39 CMHCs in its service area approximately \$96.5 million for partial hospitalization services rendered from the inception of the outpatient PPS in August 2000

through June 2003. Of these payments, \$57.9 million (approximately 60 percent) represented outlier payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether TriSpan calculated Medicare outlier and per diem payments to CMHCs in accordance with Medicare reimbursement requirements.

Scope

Our audit covered the \$43.3 million in outlier payments that TriSpan made to 38 CMHCs for services rendered between August 1, 2000, and June 30, 2003.¹ We reviewed the elements of the outlier payment calculation, which included the per diem payment calculation. During that analysis, we noted an error in the per diem calculation; therefore, we expanded our scope to include almost \$34.8 million in per diem payments to CMHCs for the same period.

We did not review TriSpan's overall internal control structure. As part of our limited tests of internal controls, we reviewed TriSpan's processes for accepting cost reports, processing claims, auditing cost reports, and establishing and revising cost-to-charge ratios.

We performed fieldwork at TriSpan in Jackson, Mississippi.

Methodology

We reviewed the Balanced Budget Act of 1997, the Balanced Budget Refinement Act of 1999, the Code of Federal Regulations, the Federal Register, program memorandums, and Medicare manuals as they pertained to outlier and per diem payments for partial hospitalization services. We also interviewed TriSpan and CMS officials.

We analyzed the elements used to calculate outlier payments, such as the cost-to-charge ratio structure and the timing of updates, and we reviewed the policies and procedures that TriSpan used to establish and update cost-to-charge ratios.

From TriSpan, we obtained (1) worksheets from cost reports for the FYs that ended between 1997 and 2002, (2) documentation detailing cost-to-charge ratio calculations, and (3) information from the online system that identified the cost-to-charge ratio effective dates and geographic wage index factors. We identified the cost reports that TriSpan used to establish cost-to-charge ratios.

We extracted detailed claim information from CMS's Standard Analytical File using the Data Extract System for partial hospitalization claims from August 1, 2000, to June 30, 2003.

¹The payments covered in this report do not include those to one CMHC that we covered in "Review of TriSpan Health Services's Payments to Synergy Behavioral Health for Partial Hospitalization Services for the Period August 1, 2000, Through June 30, 2003" (A-06-04-00032).

For each claim, we independently recomputed the outlier and per diem payments from data in the Standard Analytical File. Therefore, we considered the net effect of all errors in computing the overpayment and did not rely on a statistical projection. We shared our results with TriSpan.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

TriSpan did not always calculate Medicare outlier and per diem payments to CMHCs in accordance with Medicare reimbursement requirements. In calculating outlier payments, TriSpan:

- used incorrect cost report information to compute some cost-to-charge ratios,
- incorrectly entered one cost-to-charge ratio in the outpatient provider-specific file within the claim-processing system, and
- improperly updated some cost-to-charge ratios.

In calculating per diem payments, TriSpan assigned the wrong geographic wage index factor to certain CMHCs.

These errors occurred because of weaknesses in TriSpan's internal controls. Because TriSpan used incorrect cost-to-charge ratios and wage index factors, it overpaid CMHCs \$7,958,659.²

FEDERAL REQUIREMENTS

Establishing Cost-to-Charge Ratios

On September 8, 2000, CMS issued to fiscal intermediaries Program Memorandum A-00-63 (effective August 1, 2000) on how to compute outpatient PPS outlier payments. The memorandum required intermediaries to use FY 1997 cost reports to calculate a cost-to-charge ratio for each CMHC. However, for CMHCs that did not have 1997 cost reports, CMS required intermediaries to use the most recent cost report available. For CMHCs that did not have a full-year cost report available, CMS required intermediaries to use the statewide cost-to-charge ratio currently in effect.

CMS Program Memorandum A-00-63 also requires fiscal intermediaries to use provider-specific cost-to-charge ratios to convert providers' billed charges to costs when calculating outlier payments. As part of the computations, fiscal intermediaries compare converted cost figures with a prescribed threshold. Costs that are above that threshold qualify for outlier payments. CMS Program Memorandum A-00-63 states that the cost-to-charge ratio can be computed using

²We identified a total overpayment of \$16.2 million. Because we covered \$8.2 million of the total in another report (A-06-04-00032) on a specific CMHC, this report discusses overpayments for all other CMHCs in TriSpan's service area.

Form 2088-92, worksheet C, page 2.³ Specifically, fiscal intermediaries are to calculate the cost-to-charge ratio by dividing costs from line 39.01, column 3, by charges from line 39.02, column 3. Worksheet instructions indicate that line 22 on worksheet D should contain a figure identical to that on line 39.02, worksheet C.

The outpatient provider-specific file within the claim-processing system contains the information, including the cost-to-charge ratio, effective date, and geographic wage index factor, that the pricing software needs to calculate outlier and per diem payments. Program Memorandum A-00-36 and the “Medicare Claims Processing Manual” (CMS Publication 100-04), section 50.1, explain how the outpatient provider-specific file must be updated. Section 50.1 provides:

FIs [fiscal intermediaries] must maintain the accuracy of the data, and update the file as changes occur in data element values An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Adjusting Payments To Reflect Geographic Wage Variations

Section 4523 of the Balanced Budget Act of 1997 requires per diem and outlier payments to be adjusted to reflect geographic differences in labor-related costs. Each year CMS publishes geographic wage index factors in the Federal Register.

Updating Cost-to-Charge Ratios

On January 17, 2003, CMS issued Program Memorandum A-03-004 to address its concerns about excessive outlier payments to CMHCs. CMS instructed fiscal intermediaries to update cost-to-charge ratios by April 30, 2003, and each time a more recent cost report becomes available. Program Memorandum A-03-004 states that cost-to-charge ratios may be revised more often if an intermediary believes that a change in a provider’s operations materially affects its costs or charges. Each revised cost-to-charge ratio must be entered in the outpatient provider-specific file no later than 30 days after the date of the most recent tentative or final cost report settlement.

Authority To Retroactively Adjust Outlier Payments

The “Medicare Financial Management Manual,” Chapter 3, section 90.1, states that providers remain liable for overpayments due to clerical or mathematical errors by the fiscal intermediary or by the provider in calculating reimbursement or charges. For payments under a PPS, Federal courts have upheld CMS’s policy of not revisiting those payments when there have been errors in the calculation of wage indexes, outlier thresholds, or other estimates on which national or regional PPS rates and adjustments depend. By contrast, overpayments to particular providers that result from clerical or mathematical errors by the intermediary or the provider do not affect national or regional PPS payments or adjustments and therefore are not governed by these decisions.

³Worksheet C is entitled “Apportionment of Patient Service Costs.”

IMPROPER CALCULATION OF OUTLIER PAYMENTS

When calculating outlier payments under the outpatient PPS, TriSpan made several errors. For some CMHCs, TriSpan made multiple errors.

On August 1, 2000, TriSpan initially assigned all CMHCs the statewide cost-to-charge ratio. After CMS issued Program Memorandum A-00-63 in September 2000, TriSpan began calculating provider-specific cost-to-charge ratios. However, TriSpan's calculation of these ratios did not fully comply with Medicare reimbursement requirements.

TriSpan Used Incorrect Cost Report Information To Compute Cost-to-Charge Ratios

TriSpan did not follow CMS guidance (Program Memorandum A-00-63) on using cost reports to compute provider-specific cost-to-charge ratios. Specifically:

- For 10 CMHCs, TriSpan used partial-year cost reports, rather than the required latest full-year cost reports, to calculate provider-specific cost-to-charge ratios. For 1 of the 10 CMHCs, TriSpan later recalculated the cost-to-charge ratio based on the latest full-year cost report.
- For four CMHCs, TriSpan recognized that the FY 1997 cost reports were partial-year cost reports but still did not use the latest full-year cost reports, which in most cases were from FY 1999. Instead, TriSpan used FY 1998 full-year cost reports.
- For two CMHCs, TriSpan used figures that the CMHCs had inaccurately reported on worksheet D of their cost reports to calculate cost-to-charge ratios.

TriSpan overpaid CMHCs \$7,613,073 because it used incorrect cost report information to calculate initial cost-to-charge ratios.

TriSpan Incorrectly Entered One Cost-to-Charge Ratio in the Outpatient Provider-Specific File

For one CMHC, TriSpan incorrectly entered the cost-to-charge ratio in the outpatient provider-specific file within the claim-processing system. As of August 1, 2000, when TriSpan assigned the statewide cost-to-charge ratio, the CMHC had not submitted its first full-year cost report. In January 2001, TriSpan erroneously used a partial-year cost report to establish the CMHC's provider-specific ratio. Pursuant to Program Memorandum A-00-63, TriSpan should have left the CMHC's cost-to-charge ratio at the statewide rate until September 2002, when it received the provider's first full-year cost report.

When TriSpan entered the revised cost-to-charge ratio based on the partial-year cost report, it did not change the corresponding effective date in the outpatient provider-specific file. TriSpan should have added an additional complete record showing the new cost-to-charge ratio and the

January 2001 effective date of the change. Instead, TriSpan updated only the cost-to-charge ratio and left the effective date as August 1, 2000.

TriSpan overpaid the CMHC \$20,330 by not entering a complete record, including the effective date of the change.

TriSpan Improperly Updated Cost-to-Charge Ratios

TriSpan did not update the cost-to-charge ratios for six CMHCs in accordance with CMS guidelines (Program Memorandum A-03-004). Specifically:

- TriSpan did not update the cost-to-charge ratios for two CMHCs within the required 30 days after the cost reports were tentatively settled. TriSpan updated the ratios for these CMHCs 269 days and 6 days late, respectively.
- TriSpan did not revise the cost-to-charge ratios for four CMHCs based on the most recent tentative or final cost reports available.

As a result, TriSpan overpaid CMHCs \$55,474. During our audit, TriSpan stated that it implemented a tracking system in April 2005 to help monitor when cost reports are settled and when cost-to-charge ratios are updated.

IMPROPER CALCULATION OF PER DIEM PAYMENTS

Beginning August 1, 2000, TriSpan assigned the wrong geographic wage index factor to five CMHCs. Using the wrong wage index factor affects the per diem rate regardless of whether a particular claim also qualifies for an outlier payment. By using the wrong wage index factors, TriSpan overpaid two CMHCs \$269,782 in per diem payments. For two other CMHCs, there was no impact because these CMHCs did not submit any claims after August 2000. For the remaining CMHC, the wage index error incorrectly increased per diem payments by \$114. During our audit, TriSpan stated that it had revised its procedures and was working with its claims department to adjust the claims.

INADEQUATE INTERNAL CONTROLS

TriSpan's internal controls did not prevent or detect the improper payments that we noted. TriSpan's "Provider Reimbursement Operation Procedure Manual" established policies and procedures to calculate and update CMHCs' cost-to-charge ratios. However, TriSpan did not review past ratio calculations for accuracy or monitor outlier payments after implementing these policies and procedures.

TriSpan incorrectly used worksheet D rather than worksheet C of the cost report to calculate two CMHCs' cost-to-charge ratios because the cost-reporting instructions in the "Medicare Provider Reimbursement Manual," part II, stated that the costs on worksheet C should flow directly to worksheet D. Therefore, TriSpan believed that the costs would be the same on both worksheets.

Additionally, TriSpan interpreted “latest” full-year cost report to mean the next full-year cost report available after FY 1997.

TriSpan interpreted the “effective date” of the calculation to be the effective date of CMS Program Memorandum A-00-63, which was August 1, 2000. Therefore, even if TriSpan had entered a new and complete record, TriSpan still would have entered the cost-to-charge ratio’s effective date as August 1, 2000, rather than the date TriSpan computed the provider-specific cost-to-charge ratio. Furthermore, according to TriSpan, Program Memorandum A-00-63 did not require that the provider’s first full-year cost report be submitted by August 2000 to use a provider-specific ratio rather than the statewide cost-to-charge ratio.

The “Medicare Intermediary Manual” (CMS Publication 13-2), section 2901.3, requires fiscal intermediaries to ensure that Medicare pays neither more nor less than what is appropriate and to implement proper Medicare reimbursement policy. If TriSpan had more carefully reviewed the cost-to-charge ratio and per diem computations and followed CMS’s guidance requiring a new, complete record when updating cost-to-charge ratios, it would have prevented the payment errors. Moreover, given the amount of outlier payments relative to total payments to CMHCs, we believe that more active monitoring of the outlier payment process by TriSpan would have detected the outlier errors. However, TriSpan officials thought that the program safeguard contractor was responsible for monitoring outlier payments.

OVERPAYMENTS

Because TriSpan used incorrect cost-to-charge ratios and wage index factors, it overpaid CMHCs \$7,958,659 for partial hospitalization claims with dates of service from August 1, 2000, through June 30, 2003.⁴

RECOMMENDATIONS

We recommend that TriSpan:

- recover \$7,958,659 in improper outlier and per diem payments for services rendered between August 1, 2000, and June 30, 2003;
- review claims with dates of service subsequent to our audit period to ensure that they were paid in accordance with Medicare reimbursement requirements and make any necessary financial adjustments; and
- implement internal controls to ensure that future outlier and per diem payments are calculated with the correct cost-to-charge ratio, effective date, and wage index factor.

⁴See footnote 2 on page 4.

TRISPAN COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

TriSpan's written comments on our draft report are included in their entirety as the Appendix. In summary, TriSpan disagreed in part that it made errors when it initially established CMHC payments. TriSpan also disagreed with the causes that we identified and with our first and last recommendations. However, TriSpan agreed that it had not used the latest full-year cost reports for four CMHCs, had assigned the wrong geographic wage index factors, and had not updated cost-to-charge ratios in accordance with CMS guidance. TriSpan did not fully address the second recommendation to review all claims subsequent to our audit period because TriSpan stated that it was limited to reviewing and adjusting the claims available on the Fiscal Intermediary Standard System.

TriSpan's comments did not provide any additional information that would lead us to change the findings, causes, or recommendations included in the draft report.

Use of Partial-Year Cost Reports

TriSpan Comments

With respect to our finding that TriSpan used partial-year cost reports to calculate cost-to-charge ratios for 10 CMHCs, TriSpan disagreed in the case of 4 CMHCs. TriSpan asserted that the cost reports for the four CMHCs reflected full fiscal periods.

Office of Inspector General Response

The 10 CMHCs in our finding did not include 1 of the 4 CMHCs that TriSpan referenced. For the three other CMHCs, we are not disputing that the providers' cost reports, as presented to the fiscal intermediary, covered a full "fiscal period" because the beginning and ending dates on the cost reports reflect a full year. However, according to the "Provider Reimbursement Manual," Part 2, Chapter 1, section 102, if a provider's effective date of participation in the Medicare program is not until sometime after the start of the fiscal year, the cost report is still considered a "short period," or partial-year, cost report. This is consistent with the observation that, for Medicare purposes, the costs presented in the reports reflected only a partial year because the three CMHCs began participating in Medicare after the start of the year. Therefore, we still believe that TriSpan computed their cost-to-charge ratios incorrectly.

Use of Inaccurate Cost Report Figures

TriSpan Comments

TriSpan agreed that it had used worksheet D instead of worksheet C to compute the cost-to-charge ratios for two CMHCs. However, TriSpan disagreed that its calculation was improper. TriSpan stated that worksheet D should be acceptable because the charges should flow directly from worksheet C to worksheet D and because CMS's guidance at the time did not require the

use of worksheet C. TriSpan also stated that because the charges on the providers' cost reports were different on the two worksheets, the providers did not correctly complete the cost reports.

Office of Inspector General Response

We agree that charges should flow directly from worksheet C to worksheet D. Therefore, according to worksheet instructions, the figures on the two worksheets should have been identical. However, because of an error in the completion of worksheet D by the CMHCs, the figures were different. TriSpan should have verified that the Medicare charges on the two worksheets were the same. Had TriSpan done so, it would have noticed the discrepancy and could have followed up with the CMHCs to determine the reason for the discrepancy. TriSpan thus could have avoided paying millions of dollars in error.

Incorrectly Entered Provider-Specific Ratio

TriSpan Comments

TriSpan disagreed that the use of August 1, 2000, as the effective date of one cost-to-charge ratio was incorrect. TriSpan asserted that it correctly used August 1, 2000, because Change Request 1310 stated that changes were effective then.

Office of Inspector General Response

Program Memorandum A-00-36 (issued on June 1, 2000) and the "Medicare Claims Processing Manual," section 50.1, support our position that "effective date of the change" refers to the date of a change in the data element, not the effective date of Change Request 1310.

Inadequate Internal Controls

TriSpan Comments

TriSpan disagreed that it did not have adequate internal controls in place. TriSpan stated that it may have had some initial weaknesses in its procedural steps until it finalized and documented the approved policies and procedures for calculating cost-to-charge ratios. However, TriSpan stated that it did have internal controls in place based on the CMS guidance at that time. Additionally, TriSpan explained that with the implementation of any new payment system or policies, it takes time to fully develop procedures and quality assurance checks. TriSpan stated that it had recognized areas needing improvement and detailed several enhancements it had made.

Office of Inspector General Response

We acknowledge that TriSpan has enhanced its internal control procedures. However, during our audit, TriSpan's controls did have weaknesses. TriSpan's comments confirm that procedures were not fully in place when TriSpan calculated Medicare outlier and per diem payments.

Recovery of Overpayments

TriSpan Comments

TriSpan stated that CMS precluded it from making any adjustments to recover outlier payments. TriSpan recommended that we work directly with the providers to collect the payments.

Office of Inspector General Response

We do not have authority to collect payments directly from a provider. Furthermore, the “Medicare Financial Management Manual,” Chapter 3, section 90.1, states that providers are liable if they receive an overpayment as a result of the fiscal intermediary’s mathematical or clerical error in calculating reimbursement. We have added language to the report clarifying that retroactively adjusting outlier payments does not conflict with CMS’s prospective-only policy with respect to PPS payments. Therefore, we continue to recommend that TriSpan recover the overpayments.

APPENDIX



TRISPAN
HEALTH SERVICES
MEDICARE PART A INTERMEDIARY
A CMS Contracted Intermediary

www.trispan.com

P. O. Box 23046 • Jackson, MS • 39225 3046
1064 Flynt Drive • Flowood, MS • 39232-5570

February 17, 2006

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Subject: Report Number A-06-04-00065
Response to Draft Findings of the Review of TriSpan Health Services' Payments
to Community Mental Health Centers (CMHCs) for Partial Hospitalization
Services for the Period August 1, 2000, Through June 30, 2003

Dear Mr. Sato:

We have reviewed the draft findings and recommendations based on your review of TriSpan's payments to CMHCs for the period of August 1, 2000, through June 30, 2003. We previously responded to draft findings, but have not received a formal response. Therefore, we recommend that open issues be resolved prior to issuing a final report. The open issues are summarized as follows:

- *We are precluded by CMS from making any adjustments for the purpose of recovering outlier payments. We recommend that OIG work directly with the provider to collect the payments made to the CMHCs for outlier payments. Since we are not authorized to correct outlier payments, we ask that this recommendation be removed from the final report.*
- *We disagree that partial year cost reports were used to compute the cost-to-charge ratios (CCRs) for 10 CMHCs identified in the report.*
- *We disagree that the use of Worksheet D instead of Worksheet C to calculate the cost-to-charge ratio for several CMHCs was incorrect because CMS' instructions at the time did not require the use of Worksheet C. The charges should flow directly from Worksheet C to Worksheet D; however, the provider did not correctly complete their cost report. The final report should reflect this issue as a provider error in completion of their cost report.*



Mr. Gordon L. Sato

Page 2

February 17, 2006

- *We disagree that the use of August 1, 2000, as the effective date is incorrect.* CMS has indicated that our use of August 1, 2000, is correct. This is definitely not an error and should be removed from the final report.
- *We disagree that we did not have adequate internal controls in place and our interpretation of the instructions were incorrect.* We agree that some weaknesses in the review process resulted in the use of an incorrect wage index. Errors also occurred because of the provider's error in completing their cost report; however, we have internal controls in place that have continued to be refined as CMS has issued additional instructions.

The following are our detailed responses and comments to the findings and recommendations identified in the draft report:

- Finding 1:** TriSpan did not always calculate Medicare outlier and per diem payments to CMHCs in accordance with Medicare reimbursement requirements. When TriSpan initially established CMHC payments under the OPPS.
- A. TriSpan used the wrong cost report information to calculate cost-to-charge ratios (CCRs).
- For 10 CMHCs, TriSpan used partial cost-reporting periods, rather than the required latest full-year cost reports, to calculate CCRs. For two of the CMHCs, TriSpan later recalculated the CCRs based on more recent cost report; however, in one case, the recalculation still used incorrect information.
 - For four CMHCs, TriSpan recognized that the FY 1997 cost reports were partial-year cost reports but still did not use the latest full year cost reports, which in most cases were from FY 1999. Instead, TriSpan used FY 1998 cost reports.
 - For two CMHCs, TriSpan used worksheet D from the cost reports, instead of worksheet C, to calculate CCRs.
- Response:** We disagree that TriSpan did not calculate Medicare outlier payments in accordance with Medicare reimbursement requirements. We disagree that partial year cost reports were used for 4 of the 10 cost reports. The fiscal period on the 4 reports reflected a full fiscal period.

Mr. Gordon L. Sato
Page 3
February 17, 2006

We agree that for 4 CMHCs, we used the 1998 cost report to compute the initial CCR in the absence of the 1997, based on the interpretation of "the latest full year cost report in the absence of the 1997 cost report." Under current policy instructions, we are updating the ratios based on the latest tentatively settled or audited cost report. The table below reflects the difference in the ratios.

| Provider Number | Cost Report Used | Full Year Cost Report | Difference |
|-----------------|------------------|-----------------------|------------|
| 19-4620 | .904 | 1.045 | .141 |
| 19-4623 | .853 | 1.038 | .185 |
| 19-4643 | .424 | .715 | .291 |
| 19-4647 | .801 | .890 | .089 |

We agree we used Worksheet D to compute the ratios for 2 CMHCs; however, we disagree that the use of Worksheet D instead of Worksheet C, to calculate the CCRs were improper because CMS' instructions did not require the use of Worksheet C only. The instructions in Change Request 1310 did not state that we must use Worksheet C to calculate the CCR; instead, these instructions state "the calculation can be made using Form CMS 2088-92, Worksheet C, page 2."

Furthermore, based on the cost reporting instructions in the Medicare Provider Reimbursement Manual Part II, the costs on Worksheet C should flow directly to Worksheet D. The cost reporting instructions state that CMHCs are "... to enter in the applicable column the cost of services provided from Worksheet C column 6, Line 39 on Column D Line 1." Therefore, our position is that Worksheet D should be an acceptable worksheet.

The charges on the cost reports as submitted by the providers were different on Worksheet C versus Worksheet D. Thus, the providers did not correctly complete their Medicare cost report. Determination of actual charges and related rework of the Medicare cost report is a part of the provider's final settlement process that occurs at a later date. We agree that by utilizing the charges on Worksheet D instead of C, we computed different CCRs, but we contend that our calculation of outlier payments was in accordance with Medicare requirements.

Mr. Gordon L. Sato
Page 4
February 17, 2006

- B. TriSpan did not correctly enter the provider specific-cost-to-charge ratios in the outpatient provider-specific file, for one CMHC TriSpan did not properly enter the CCR in the outpatient provider specific file and used a partial year cost report. and,

Response: We agree that we used a cost report with the reporting period of 9/30/2000 to calculate the CCR for one CMHC. Prior to the cost report being submitted the provider was paid using the statewide average and later updated based on the instructions in Change Request 1310. The CMHC submitted a cost report for the year ending 9/30/2000 on January 4, 2002; however, because of the nationwide cost reporting problems and the extension on filing cost reports, we were unable to accept the cost report under the normal acceptability process. This cost report was used to establish the CCR for the year ending 09/30/2000. The full year cost report was accepted on July 22, 2002.

However, we disagree that we incorrectly entered the effective date on the outpatient provider specific file (OPSF). Change Request 1310, dated September 8, 2000, provides instructions for calculating the CCRs and states the changes are effective August 1, 2000. Therefore, entries we made into the OPSF had an effective date of August 1, 2000. Furthermore, Change Request 1310 did not specify that the first full year cost report had to be submitted by August 2000 for the original update to pay claims under OPPS. We received guidance from a CMS representative who stated, "August 1, 2000 was an appropriate date." Additional instructions for calculating provider specific CCRs were issued in Change Request 2197, dated January 17, 2003. After receipt of Change Request 2197, we made changes to our procedures to incorporate the new requirements from CMS. We began computing the CCRs based on the latest tentatively settled or final settled full year cost reporting period. We made the CCR effective based on the date it was entered in the OPSF. Prior to issuance of Change Request 2197, however, we appropriately entered August 1, 2000, as the effective date for CCRs, based on CMS' instructions.

- C. TriSpan assigned the wrong geographic wage index factor.

Response: We agree that the incorrect geographic area wage index was assigned to five CMHCs. However, two of the CMHCs have no effect because the facilities have not received any claims payments. Also, for one of the three other CMHCs, the dollar impact was immaterial.

Mr. Gordon L. Sato

Page 5

February 17, 2006

Finding 2: TriSpan did not update CMHCs' cost-to-charge ratios in accordance with CMS guidelines. TriSpan did not update the CCRs for six CMHCs in accordance with CMS guidelines. Specifically:

TriSpan did not update the CCRs for two CMHCs within the required 30 days after the cost reports were tentatively settled. TriSpan updated the ratios for these CMHCs 269 days and 6 days late, respectively.

TriSpan did not revise the CCRs for four CMHCs based on the latest available tentatively settled or final cost reports.

Response: We agree that we did not update the CCRs for the CMHCs identified above within the required time timeframes and based on the latest available cost reports. Initially, after receipt of the revised instructions in Change Request 2197, we developed procedures and identified processes to ensure effective implementation of the instructions. Upon completing the initial phase of the implementation of Change Request 2197, we focused on identifying the most effective way to receive notification of a completed tentative settlement or final settlement. As we worked through the processes, we made modifications to our procedures to connect missing links in our processes based on the CMS instructions to ensure updates are made within 30 days of the latest settled cost report and based on the latest available tentatively settled or final cost reports.

Finding 3: These errors occurred because of weaknesses in TriSpan's internal controls and its incorrect interpretation of CMS instructions.

Response: We disagree that the errors occurred because TriSpan did not have adequate internal controls and incorrect interpretation of CMS instructions. The entry of the ratios was made based on interpretation of the existing instructions at the time of implementation of OPPS. We believe our interpretation versus the OIG interpretation of CMS instructions is debatable. We maintain that internal controls were adequate related to the entry of the CCR. We contend that some of the CMHCs ratios were computed based on the incorrect cost report preparation by the provider. The calculation was correct, but the charges the provider reported on Worksheet D were different from Worksheet C.

We agree that weaknesses in the review process of the wage index data resulted in the incorrect APC payments; however, we believe we have adequate internal controls for entry of the wage data on the provider specific file.

Mr. Gordon L. Sato
Page 6
February 17, 2006

Recommendations:

We recommend that TriSpan:

- recover \$7,958,659 in improper outlier and per diem payments for services rendered between August 1, 2000, and June 30 2003;);
- review claims with dates of service subsequent to our audit period to ensure that they were paid in accordance with Medicare reimbursement requirements and make any necessary financial adjustments; and
- implement internal controls to ensure that future outlier and per diem payments are calculated with correct cost-to-charge ratios, effective dates, and wage index factors.

Response:

Based on current regulations in section 412.116 of the Code of Federal Regulations (CFR), the outlier payments are considered "final payments." We recognize that some of the CMHCs may have received higher outlier payments because the CCR was computed using the charges the provider incorrectly reported on Worksheet D and utilization of the incorrect wage index factor. However, we are not authorized by CMS to recover and adjust claims to recover the outlier payments because of CCRs, adjustments made to cost or charges at the time of audit, or any other reason that may result in deemed improper outlier payments. A response we previously received from CMS states, "CMS will not allow intermediaries to make adjustments to claims to correct outlier payments at this time."

We have conducted a thorough review subsequent to the audit period of all the entries made to the provider specific file to ensure the accuracy of the file. We have also made modifications to enhance our quality review of the provider specific file to ensure accuracy.

We disagree that we do not have documented internal policies, procedures, and controls relating to CCR calculations and update of the wage index factor. We initially followed the instructions in Change Request 1310 to establish the CCRs used to compute outlier payments under OPSS. After receipt of the revised instructions in Change Request 2197 for updating of CCR on an ongoing basis, we developed procedures and identified processes to ensure effective implementation of the instructions. Upon completing the initial phase of the

Mr. Gordon L. Sato

Page 7

February 17, 2006

implementation of Change Request 2197, we focused on identifying the most effective way to compute and enter CCRs into the provider specific file as a result of a completed tentative settlement or final settlement. As we worked through the processes, we made modifications to our procedures based on the CMS instructions.

With the implementation of the instructions, initially we may have had some weaknesses in our procedural steps until we finalized and documented the approved policies and procedures for calculating the CCRs, but we did have internal controls in place based on the instructions at that time. With the implementation of any new payment system or policies, it takes time to fully develop procedures and quality assurance checks. We recognized and identified areas of improvement after the implementation of OPPS and the related calculation of CCRs. The following enhancements were made:

1. We modified and revised our procedures to enhance the quality of our work. For example, we revised the CCR computation form to include sign off by the individuals who compute, review, input, and verify the CCRs.
2. We also modified our calculations to include an automatic default to the statewide average when the CCR exceeds 1.0.
3. We have included the update of the CCRs as a part of a monthly monitoring and reporting activity.
4. We created a log to monitor timeliness for completing the CCRs based on the date the tentative settlement or final settlement is complete.
5. We developed a database for cost report activities that includes a feature that automatically generates an email to notify the Supervising Senior Reimbursement Auditor that a tentative or final settlement has been completed.
6. We enhanced our process for overall update of the provider specific files. Each entry made by an Auditor is reviewed by the Supervisor.
7. We modified our acceptance process to include a review of the cost report to determine the accuracy of the worksheets, and a notification is sent to the provider in the absence of Worksheet C.

Mr. Gordon L. Sato
Page 8
February 17, 2006

8. We are continuously monitoring the instructions for CCRs and modifying our procedures to enhance our processes. We recently developed a detailed checklist that is used by the supervisor as a verification check that the latest tentatively or final settled cost report is used, the cost report is for a full year based on STAR data, and to determine if the statewide average should be used.

We believe we revised our procedures to include processes to avoid the areas of concern you identified in our early processes established with the implementation of OPPS and update of the CCRs.

In addition, on April 17, 1998, the Dallas Regional Office of OIG issued a report to TriSpan Health Services noting that outlier claims were paid incorrectly because the capital CCRs were not properly updated. We faxed a copy of the report the Atlanta Regional Office (RO) of CMS on March 13, 2001, to determine if the intermediary would be able to make any retroactive correction to outlier payments, based on the language in the manual instructions that outliers are prospective payments and may not be changed retroactively. A response was received from Brett James with CMS' Central Office on September 23, 2003, that the Office of General Counsel (OGC) had revised the original response from CMS RO and *TriSpan would not be able to recoup the overpayments for outliers*. Attached is a copy of the response from OGC. Office of Inspector General Note: The attachment has been redacted because it contained information which may be considered privileged/confidential.

Moreover, CMS issued a Joint Signature Memorandum (JSM) on April 22, 2002, that communicated that CMS was aware that some intermediaries may be using incorrect hospital specific data to compute outlier payments. CMS instructions in the memorandum stated, "We are not asking FIs to make any changes to settled cost reports. We are instructing FIs to ensure that the operating and capital cost-to-charge ratios in the current provider specific files are correct". A copy of the JSM is attached.

Based on the response from OGC and CMS Central Office, there is *no basis* for retroactively correcting outlier payments even if OIG has identified errors on prior CCR entries in the provider specific file. We can only ensure the current updates are correct for open cost reports. The time and costs associated with correcting errors on CCRs for paid claims would be significant. It would involve:

- 1) Requesting Arkansas system programming and CPU time to identify and re-run the claims as adjustments.
- 2) Identifying cost reports to reopen (reopening will be determined based on the aggregate reimbursement impact adjustments); and
- 3) Generating PS&Rs for all affected providers after the claims have been adjusted.

Mr. Gordon L. Sato
Page 9
February 17, 2006

provider to collect the payments made to the CMHCs for improper outlier payments and per diem payments.

In summary, we followed the instructions in Change Requests 1310 and 2197 as these Change Requests were issued. As we are precluded by CMS from adjusting claims to recover outlier payments, we ask that OIG reconsider the recommendation of recovering outlier payments of \$7,958,659. We have completed our review and verification of the accuracy of OPSF entries. However, with respect to review and adjustment of claims, we are limited to the claims data available on the system. We are unable to review and adjust actual claims data that is older than that allowed by the Fiscal Intermediary Standard System (FISS).

Thank you for the opportunity to offer comments on the draft findings and recommendations. We appreciate any recommendations to our processes that we have not presently included in our revised procedures.

Sincerely,



Sheila B. Thomas, CPA
Director, Provider Reimbursement

Attachments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

DATE: April 22, 2002

FROM: Director, Financial Services Group
Office of Financial Management

Deputy Director for Contractor Management
Center for Medicare Management

SUBJECT: Correct Calculation of Hospital Cost-to-Charge Ratios

TO: All Fiscal Intermediaries (FIs)

The Centers for Medicare & Medicaid Services (CMS) has learned that some FIs throughout the country may be using incorrect hospital specific charge data to compute cost outlier payments for hospitals. The result can be errors in outlier payment amounts. The intent of this memorandum is to bring the problem to your attention and request that you ensure that the cost-to-charge ratios are correctly calculated for all open hospital cost reports.

The problem appears to stem from intermediaries not reconciling inpatient Medicare charges from the Provider Statistical and Reimbursement (PS&R) report to the cost report. In addition, in some instances routine charges were not included in the as-filed cost reports because the providers and some FIs believed the revised CMS 2552-96 did not have data fields to include routine charge data. (There are data fields on the cost report to record this information.) As a result some FIs used the statewide averages listed in the annual Prospective Payment System (PPS) update in the Federal Register as their best alternative.¹ By using statewide averages, the FIs either over or under paid providers for outlier payments.

We are not asking you to make any changes to settled cost reports. We are instructing

¹The statewide averages are only used when the hospital's operating or capital cost-to-charge ratios fall outside parameters established by CMS in the annual update to the PPS payments.

Page 2 – All Fiscal Intermediaries

you to ensure that you calculated the operating and capital cost-to-charge ratios in the current provider specific file using the correct Medicare inpatient charges. This will require you to reconcile PS&R data to the charges on the cost report and/or ensure that the providers included charges on the as-filed cost report.

There will not be any additional funding allocated to accomplish this review. You should determine the effect on your current workload and make appropriate adjustments. If there is any impact on accomplishing the goals set forth in the Budget Performance Requirements (BPRs), then inform your regional office of any needed changes to accomplish the cost-to-charge ratio review. If you have any questions concerning this instruction, please contact Charlotte Benson at 410-786-3302 or Brett James at 410-786-9358.

/s/
Elizabeth Richter

/s/
Elizabeth Cusick

cc:
All RAs
All CCMOs
All ARAs for Financial Management
Nan Foster Reilly, Kansas City RO
Carol Plum, CMM